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the
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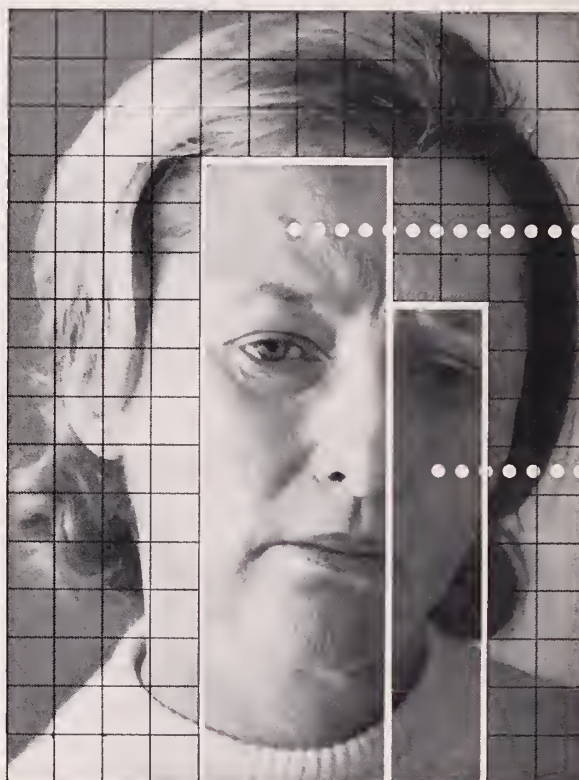
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in psychoneurotic
anxiety states
with associated
depressive symptoms

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against possible hazard.

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the pharmacology of agents em-
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slurred speech, tremor, vertigo, urinary
retention, blurred vision. Paradoxical re-
actions such as acute hyperexcited states,
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should these occur, discontinue drug. Iso-
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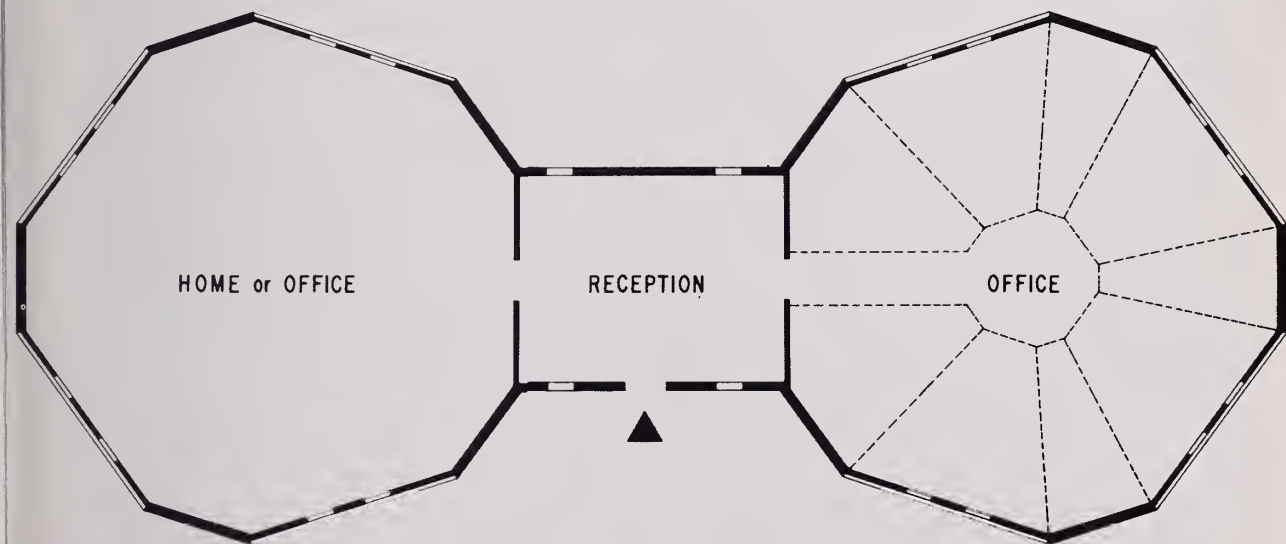
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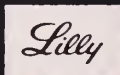
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EDITORIALS

Physician Responsibility in Child Abuse

Child abuse and neglect are receiving increasing attention in New Jersey as well as other parts of the country through articles in newspapers, radio shows, television spots, public meetings, and public and private agency efforts. (See related article, p. 605, this issue.) Some workers in the child protective service field feel that the problem has reached the point of public outrage. Once the real incidence of abuse and neglect is known, it may be found to be a more frequent cause of death in childhood than such well-known diseases as leukemia and cystic fibrosis.

There is a real suspicion that only about one-tenth of actual cases of child abuse are reported, which suggests that abuse cases are being seen and are not being recognized. Why are physicians failing to recognize or report child abuse and neglect?

It may be that the physician is reluctant to admit that the problem occurs in his own patients. He may fear having to get involved in time-consuming court appearances. He may have a fear of libel. Physician reluctance to report has been described in great detail by Kempe and Helfer.[†] Despite the passage of laws by all 50 states protecting the physician from libel there, unfortunately, has been no significant increase in the number of cases referred to public or private agencies by physicians.

Is the failure to report related to lack of familiarity with the legal responsibility? Does the physician understand that he could be sued for failing to recognize a case? * Many may not be aware of the change in the reporting law in New Jersey (Dodd Bill) which makes it possible to refer suspected patients to the Division of Youth and Family Services instead of to the County Prosecutor. Hopefully, the failure to report is not an indication of lack of knowledge

of the clinical signs and symptoms of typical abuse or neglect or the characteristics of abusing parents and abused children.

Regardless of the reasons, it is imperative that we act to identify and report cases of abuse and neglect in order to protect the child at risk and to offer help to the parents. In an effort to help with this problem, CMDNJ-Rutgers Medical School, in conjunction with the Division of Youth and Family Services, is developing a Protective Services Institute which will provide training in all aspects of abuse and neglect for professional and non-professional workers who have regular contact with children. Through training, it is hoped that there will be improvement in the understanding of the problem, better recognition, and early referral to protective services.

It is recognized that merely improving recognition and reporting is insufficient. Treatment resources must be made available to communities throughout the State. Therefore, technical assistance by consultants from the Institute will be provided to public and private agencies to improve and develop treatment services for parents and children. These services may be under the auspices of hospitals, service agencies, mental health centers, day care programs, and others.

In addition, an attempt must be made to improve the public awareness of the problem in order to gain continuing support for all constructive efforts in the field. The problem of abuse and neglect is complex, as is its pathogenesis. The physician must become aware of the extensive literature on the subject covering such areas as characteristics of abusing parents and abused children, precipitating factors in family crises, new treatment efforts developed in Denver and New York, and early identification of abusing parents. Hopefully, these comments will remind the physician of his responsibility and call to his attention new efforts to approach the problem in New Jersey.

Christian M. Hansen, Jr., M.D.

[†]Henry C. Kempe, M.D. and Ray E. Helfer, M.D., Denver

*There is such a case pending.

Shall I Report This Case?

Motivations for writing scientific papers may vary from author to author, but the primary reason for *publishing* them is to teach something or to provide information to the reader. This pertains equally to the case report as to any other medical article. The case report has a history which goes back almost four millenia antedating Hippocrates by more than a thousand years. It thus has a rich tradition and one which should be respected.

Why should one elect to prepare a case report? It may be to record the first of a kind or an example of a rare disease or abnormality. One may have successfully applied a new or unusual diagnostic or therapeutic technique to a representative but common condition. One may even wish to review a spectacular but unexpected failure, to warn of the dangers of a particular treatment, or to share some experience with his colleagues.

Narrative style is preferred for the case report, which should be presented in a clear and undistracted manner. The history, physical findings, and studies which give information bearing on the case should be included; irrelevant data should be deleted. Keep in mind that hospital charts may satisfy the records committee, but verbatim transcripts are unacceptable for a scientific publication. Delineation of all essential facts and elimination of inconsequential material are the hallmarks of a good case report. The report should be heralded by a statement of its purpose, followed straightway by the narrative material with or without side headings. A discussion of its pertinence should follow immediately and may include reference to similar citations in other scientific writings. One should not plagiarize the references of other authors simply to include the world's literature on the subject, but should cite articles that he has read and found appropriate.

A superior report of a medical case is not easy to write; a poorly written document should not be excused on the basis of the rarity or uniqueness of the instance.

A.K.

Cherish the Mobile "Think-Tank"

In these days of hectic, almost frenetic professional activities and obligations, the physician is deprived. He has almost no "quiet time" for solitary reflection, rumination, contemplation of the past, or planning for the future. Days are occupied by other people — patients, families, and co-professionals — with their needs or problems. Voids are quickly filled by professional conferences, obligatory visits to the medical record room, and encounters with office dictation equipment.

Yet, there is such time available to us all daily. Our late (or not-so-late) model automobile is the answer. Most of us spend 30 minutes or more daily traveling from home to office to hospital to conferences to anywhere, and hating every minute of this "waste of time." Don't hate it — cherish it.

Make your automobile your personal "think-tank" and use that time for your own benefit. Of course, you can convert your car into a concert hall, with appropriate cassette players, and plan your program a week ahead of time with symphonies and opera to fit your taste. If you are a frustrated conductor, please keep one hand on the steering wheel (or else use your chariot as a "chapel" and say a prayer before you pull away from the curb.)

Some of us transform our auto into a "conference room" by listening to taped recordings of lectures, conferences, and panel discussions. One colleague, who has a chauffeur (for health reasons), dictates letters, operative notes, and other professional correspondence while traveling from hospital to hospital. The avowed purpose is to permit more recreational time at night and on weekends — and it works.

Under no circumstances should you scuttle your opportunity by installing a mobile telephone. Even the "air-page" receiver is to be frowned upon as an agent of the devil, exceeded only in its diabolical attributes by the bedside telephone.

Rejoice and cherish your moments of solitude — they are so few!

A.K.

The uterine tube has traditionally been considered to be a conduit between the uterine cavity and the ovary for the passage of gametes and zygotes. Over the last two decades, however, the role of the tube in the reproductive capacity of the female has been greatly expanded. The mucosa of the tubal lumen varies in its cellular detail, in ciliogenesis, and in its secretory function with the phase of the menstrual cycle. Estrogen is stimulatory to most of these processes, while progesterone inhibits them. Sperm capacitation occurs primarily within the tubal lumen. The metabolic rate of migrating spermatozoa is significantly increased by tubal secretions. Pickup and transport of ova from the peritoneal cavity is dependent upon fimbrial ciliary motion and upon peristalsis of tubal musculature. Understanding tubal physiology should provide an excellent basis for newer methods of contraception, and for improved therapy of the "tubal factor" in the infertile woman.

The Physiology of the Uterine Tube

**R. J. DiBenedetto, M.D.,
C. A. Gregori, M.D., and
James L. Breen, M.D./Livingston***

Gabriele Fallopio (1523-1562), a sixteenth century Italian anatomist, was first to formally describe the uterine tubes, which bore his name for many years. From the time of Fallopio to the mid-twentieth century the oviduct had been considered to be, as its name implies, simply a conduit for passage of the ovum from the ovary to the uterine cavity. Since the early 1950's, however, the activity of the uterine tube has become the subject of considerable investigation and scrutiny. The intricate biochemical and physical interactions comprising tubal physiology result in the performance of three basic tubal functions: ovum pick-up and transport, sperm transport and capacitation, and zygote transport and maintenance.

It is the purpose of this paper to review the physiologic mechanisms responsible for these essential functions, without which fertilization and implantation cannot occur.

The Anatomy and Histology of the Uterine Tube

An understanding of tubal physiology, like that of any other organ, has as its prerequisite a thorough knowledge of its gross and microscopic anatomy.

The human oviduct arises from the uterus at the junction of the corpus and the fundus. It measures 10-12 cm. in length and is divided into

four discrete subdivisions. The first of these, the interstitial portion, arises from the superior-lateral aspect of the endometrial cavity. It maintains a minute ostium as it traverses the thickness of the myometrium, emerging at the uterine cornu just superior to the round and utero-ovarian ligaments. The isthmus, or second portion, is straight, narrow, and thick-walled. As it proceeds laterally, however, it increases in luminal diameter and decreases in the thickness of its wall. The third tubal subdivision, the ampulla, is the longest and most dilated of the four. It comprises the middle and outer two-thirds of the tube. Its wall is thin, convoluted, and easily stretched. The infundibulum is the terminal portion of the tube. It has a trumpet shape and ends in multiple fimbrial folds, giving it a fringed appearance.

The oviduct generally courses laterally and posteriorly along the lower pole of the ovary, then ascending along the mesovarial border, and finally arching downward to end opposite the medial aspect of the ovary. There are multiple normal and pathologic variations to this course, some of which can be expected to interfere with normal tubal function. In gonococcal salpingitis, for example, the tubes may be immobilized in the cul-de-sac by adhesive bands. Following a ruptured appendix, the right tube is often found adherent to the lateral pelvic wall or to the caecum. The tubes of a pelvis affected by en-

*Dr. DiBenedetto is Resident, Dr. Gregori is Assistant Director, and Dr. Breen is Director, Department of Obstetrics and Gynecology, St. Barnabas Medical Center, Livingston.

dometriosis can be bound to the ovary or to the posterior uterine peritoneum.

The wall of the uterine tube consists of three basic layers: the serous, muscular, and mucosal. The outer, or serous layer is an extension of broad ligament peritoneum that envelops the tube and forms the mesosalpinx at its lower border. Beneath the serosal layer run blood vessels and nerves in a connective tissue bed. The muscular layer consists of outer longitudinal fibers, which are an extension of myometrium; a middle circular layer, which is the true tubal musculature; and an inner layer of fibers extending into the lamina propria below. The inner, or mucosal layer, is convoluted. Its folds increase in number from three or four within the interstitial segment to an intricate, arborescent pattern in the ampulla. The lamina propria, or submucosa, is a connective tissue layer between tubal epithelium and muscularis. It corresponds to the stroma of the endometrium and undergoes a decidual reaction during pregnancy. Since it is Müllerian or paramesonephric in origin, this layer demonstrates many of the metabolic changes of endometrial stroma.¹

The mucosal epithelium consists of three distinct types of cells. These are ciliated or non-secretory cells, nonciliated or secretory cells, and intercalary or peg cells. The ciliated or secretory cell is broad and tall, with pale cytoplasm that forms a typical "halo" around the nucleus. The nucleus is large and round and is arranged well above the basement membrane, often just under the ciliated edge of the cell. Nine cilia emerge from a layer of basal granules within each cell. The cilia are long, slender structures that measure 7 to 8 microns in length.

The non-ciliated or secretory cell is also tall with cytoplasm that stains darker than that of the ciliated cell. Its height, like that of the ciliated cell, varies considerably with the phases of the menstrual cycle. The nucleus is quite cylindrical and is located just above the basement membrane. It stains more deeply than the ciliated cell nucleus, and is often seen to be extruded with the cytoplasmic secretions into the lumen of the tube. These secretions are not vacuolated, but are dispersed within the cytoplasm, part of which is lost during the secretory process.

The intercalary or peg cell consists of a slender rodlike nucleus surrounded by a small amount of cytoplasm. It is often seen squeezed between the other cell types and is most abundant premenstrually and menstrually. During menses, secretory cells which have lost part of their cytoplasmic contents bear a great resemblance to peg cells. Because transitional stages between peg cell and intact secretory cells have been described, it is now believed that these cell types represent two phases of the same life cycle.

In addition to these three types, an "indifferent" cell has been reported to lie at the base of the epithelial layer. It is more metabolically active than the other cells, and for this reason is suspected to be their progenitor.¹

The Cyclic Behavior of Tubal Mucosa

When one considers the profound changes in the endometrial cavity wrought by the female hormones, it is not surprising that the tubal mucosa, of the same Müllerian origin, displays cyclic variations under the same hormonal influences. The primary changes in tubal mucosa involve cellular height and ciliary regeneration.

Non-ciliated (secretory) cells increase in height during the follicular phase of the menstrual cycle, reach maximum height during ovulation and premenstrually, and lose their stature during menstruation and pregnancy. The ciliated (non-secretory) cells behave similarly, acquiring their greatest development during the ovulatory phase, becoming lower after ovulation, and receding in height during menses and pregnancy.¹

The growth of new cilia on the non-secretory cell, the process of ciliogenesis, also appears to be under hormonal control. Studies done on the rhesus monkey have shown that oophorectomy results in a dramatic atrophy of tubular epithelium, with complete loss of cilia from the mucosal cells. Estrogen replacement therapy, however, restores the epithelium to the fully ciliated state.² Andrews, in his study of tubal mucosa in post-partum women, concluded that oviductal epithelium under the influence of progesterone is low and deciliated. He reported that women treated with diethylstilbestrol on the

day of delivery showed an intense proliferation and hypertrophy of ciliated epithelium. Women who received both estrogen and progesterone failed to develop ciliated cells and demonstrated minimal mucosal development. Menopausal women, with low estrogen and progesterone levels, have low-deciliated tubal epithelium.³

The process of ciliogenesis is most dramatic in the fimbrial portion of the tube, in which more than 95 percent of the cells shed and regenerate their cilia each cycle. Ciliated cells of the ampulla wax and wane in height each cycle, but far fewer undergo complete loss and regrowth of their cilia. Following oophorectomy, however, ampullary ciliated cells lose nearly all of their cilia and complete regeneration can be evoked by estrogen therapy.² One might conclude, therefore, that a difference in hormonal sensitivity exists in the tube and that the fimbrial portion is more responsive to cyclic changes in estrogen-progesterone levels than the ampulla.

Ciliary action is a to-and-fro lashing with the direction of propulsion always the same. Since the cilia are bathed in tubal fluid, their motion sets up a current which aids in ovum migration along its length.¹

Tubal Fluids: Chemical Composition and Hormonal Influence

The non-ciliated cells of the tubal mucosa are responsible for the great majority of the secretory products of the organ. Transudation of plasma components, however, also contributes to the tubal fluid pool. Many investigators over the last two decades have suggested that luminal fluids of the uterine tube serve as both vehicle and nutrient media for the migrating sperm and ovum.⁴ Their studies have also disclosed variations in quantity and quality of these fluids with the phases of the menstrual cycle.

Among the electrolytes in tubal fluids, sodium is the primary cation and chloride is the major anion. Lesser quantities of potassium, magnesium, calcium, phosphate, and bicarbonate are present. Using normal and spayed ewes as subjects, it has been shown that the concentration of potassium in tubal secretions is four times that of blood, that tubal chloride

levels are 30 percent higher, and that sodium, calcium and magnesium concentrations are lower than those in plasma.⁵

All serum amino acids are present in tubal fluids, although most of them are at lower levels. Tubal enzymes are very similar to plasma enzymes, but are less concentrated. Carbohydrate enzymes, such as galactosidase and glucosidase, commonly found in seminal plasma, are completely absent from tubal secretions. Spermatozoa within the tubal lumen, therefore, must metabolize substrata different from those of the seminal pool.⁶ Protein gel and immunoelectrophoresis in human serum and tubal fluid results in very similar patterns. Immunoglobulin IGM is totally absent from tubal fluids. It is of interest that the spermotoxic protein of serum is a gamma globulin.⁷

Glucose is absent from tubal fluids of many species, including man. Lactic acid, however, is present in significant amounts and could be the primary substrate of tubal metabolism. The human endosalpinx preferentially utilizes the glycolytic pathway of metabolism. Lactate may also be a major substrate for sperm metabolism.⁸

The effects of estrogen and progesterone on endometrial and cervical secretory function are well understood. Little has been written, however, on the hormonal control of tubal secretion. It is now known that the quantity of tubal fluid begins to increase just prior to ovulation. It reaches its maximum level at ovulation, and decreases gradually during the luteal phase of the cycle. Fluid output remains low during menstruation and the early proliferative phase.⁹ Castration results in a reduction of tubal secretory activity in the test animal, but estrogen administration restores the flow rate to ovulatory levels. Progesterone given alone or with estrogen, decreases the rate of tubal fluid secretion.¹⁰

Administration of estrogen to spayed sheep causes an increase in tubal fluid potassium and bicarbonate, but diminishes magnesium levels. Carbohydrate and lactate concentrations are increased with estrogen treatment.⁵ The action of estrogen and progesterone on protein secretion

into the tubal lumen appears to be species specific, with alternating effects depending upon the species treated.

The significance of hormonally-controlled changes in tubal fluid biochemistry will be more fully appreciated only after ovum and sperm metabolism is better understood.

Tubal Influence on Spermatozoa

Once spermatozoa have entered the female reproductive tract and started their upward ascent, they leave their enzyme-carbohydrate rich seminal pool behind, and become totally dependent on the uterine tube for subsistence. In studies done mainly on rabbits and fowl, it has been shown that spermatozoa undergo a twofold to a fourfold increase in oxygen uptake while residing in the uterine tube. This augmentation in respiratory rate is considered to be an important step in sperm preparation for fertilization.

Fructose, the major carbohydrate substrate of sperm metabolism in the male, is provided by the seminal vesicles prior to ejaculation. In the female, bicarbonate, in an appropriate concentration, is responsible for the increased respiratory rate of human sperm. Succinic acid, an intermediate of the tricarboxylic acid cycle (TCA), stimulates sperm respiration to the same extent as bicarbonate. This fact suggests that by increasing the concentration of these intermediates, bicarbonate affects increased spermatozoal metabolism.¹² The concentration of bicarbonate in tubal fluids is greatest at the time of ovulation and after estrogen injection of castrated animals.⁵

In addition to altering the metabolic rate of migrating spermatozoa, the uterine tube exerts control over their distribution within its lumen. Considering the tremendous quantity of sperm deposited in the female reproductive tract, the number in the ampullary portion of the tube is remarkably low. Two mechanisms are responsible for this regulation: the release of sperm into the peritoneal cavity, and the role of the isthmus in limiting sperm ascent.⁶ Recovery of sperm in human peritoneal fluid offers direct evidence that spermatozoa reaching the fimbria are released into the peritoneal cavity.¹³ Patholog-

ical and experimental occlusion of the uterine tube shows that the sperm count is higher in the occluded tube than in a control tube freely opening into the peritoneal cavity.¹⁴

The second mechanism of sperm regulation has been demonstrated by unilateral resection of the isthmus and end-to-end anastomosis of the remaining portion. This surgical alteration in tubal anatomy results in increased numbers of spermatozoa reaching target ova and a striking incidence of polyspermy.¹⁵ The isthmic portion of the uterine tube, therefore, significantly limits the passage of sperm to the ampulla, where fertilization probably occurs. The nature of this regulation is not well understood, but its thick muscular wall and narrow lumen probably play some part. Isthmic salpingectomy (uterotubal implantation) is a surgical procedure designed to restore patency to pathologically obstructed tubes, and thereby improve female fertility. This procedure results in a high percentage of pregnancies, but also a high abortion rate and a low number of term pregnancies.¹⁶ The role of polyspermic fertilization in the low rate of term pregnancies is implicated.

Sperm Capacitation and Fertilization Within the Uterine Tube

Reproductive physiology has classically taught that the only prerequisite for successful fertilization is that a viable sperm and ovum meet sometime soon after ovulation. Over the last two decades, however, it has become apparent that spermatozoa must reside for a certain time in the female reproductive tract before they are able to penetrate the zona pellucida of the liberated ovum. The functional change that confers upon the sperm the capacity to fertilize is called capacitation, and was recognized independently by Chang and Austin in 1951. The exact nature of the relationship between sperm and the female reproductive tract is not well understood. The metabolic stimulation which sperm undergo within the uterine tube may contribute to sperm capacitation. Multiple light and electron microscopic studies have indicated that no structural change is involved in the capacitation of spermatozoa. The process is therefore a totally functional one.¹⁷

Although capacitation occurs to some degree throughout the female reproductive tract, the uterine tube is the most favorable site for its development. The time after insemination at which rabbit eggs placed in the uterus can be penetrated, indicates that sperm exposed to the uterus alone are not fully capacitated before 10 to 11 hours. If the uterotubal junction is blocked, this interval is prolonged to about 15 hours, suggesting that some tubal influence hastens the time of appearance of capacitated sperm in the uterus.¹⁸ When sperm are exposed to both uterus and oviduct, capacitation can be completed in six hours.¹⁹

Spermatozoa that successfully penetrate the cumulus oophorus and zona pellucida of the recipient ovum have undergone a morphologic change known as the acrosome reaction. This reaction involves progressive breakdown and fusion between the sperm plasma membrane and outer acrosomal membrane to form a series of vesicles.¹⁷ Uncapacitated sperm cannot undergo an acrosome reaction, and therefore are unable to break through the zona pellucida in the process of fertilization. This reaction appears to occur immediately upon completion of sperm capacitation.

Fertilization, according to most investigators, occurs in the ampullary portion of the tube, or at least in the distal one-third, between 12 and 24 hours after ovulation.²⁰ It is possible, however, that conception may occur in the peritoneal cavity, with the conceptus subsequently picked up and transported by the tube.¹³ Since viable sperm have been demonstrated in peritoneal fluid, the case for a cul-de-sac conception site is substantiated.²¹ A smooth cul-de-sac would therefore be important if fertilization is to occur. A cul-de-sac deeply divided into compartments by adhesions, or by endometriosis, may pose a serious deterrent to fertilization and to pickup of the conceptus by the tube.¹³

Wherever it occurs, fertilization chronologically follows the acrosome reaction. This reaction results in the liberation of proteolytic enzymes that dissolve the matrix between the granulosa cells surrounding the ovum. With the dissolution of the corona radiata, spermatozoa gain access to the zona pellucida, which they penetrate to

reach the vitelline surface. The egg and sperm plasma membranes then fuse, and the posterior part of the sperm head sinks into the vitellus. The anterior half of the sperm nucleus is engulfed by the egg plasma membrane within a phagocytic vesicle. The male and female pronuclei subsequently form and fuse, to complete the process of fertilization.¹⁷

When one considers that the entire female reproductive tract is governed by endocrine secretions, it is hardly surprising that sperm capacitation too is under some degree of hormonal control. The normal capacitation potential of the uterine tube is diminished after oophorectomy and restored by estrogen injections. In complete absence of estrogen, (in an oophorectomized and adrenalectomized animal), the tube retains a basal level of this activity. Capacitation is not significantly disturbed in the progesterone-dominated female, and the tube retains the basal capacitating ability in oophorectomized animals treated with progesterone.²²

In the progesterone-dominated female, the uterus loses its ability to bring about complete capacitation. Only partial capacitation occurs in the uterus of an oophorectomized animal. It must be concluded from these data that the uterine tube has a greater innate potential for capacitation than does the uterus and that this potential is increased in both sites by administration of estrogen. Progesterone exerts a depressive effect on capacitation in the uterus, but does not significantly affect this activity in the tubes.²² These considerations suggest another mechanism by which oral contraceptives might suppress fertilization.

Ovum Pickup and Transport by the Uterine Tube

The migration of the ovum after liberation from the ruptured follicle, through the uterine tube and into the endometrial cavity has been the subject of much speculation and some experimentation. No phase of human reproductive physiology has been less frequently observed than the tubo-ovarian mechanism.

This mechanism consists of two basic processes: ovum pickup from the ovary or from the

peritoneal cavity and ovum transport along the length of the tube. The forces that make ovum pickup and transport possible include ciliary motion, peristalsis of the muscular tubal wall, contraction of the ovarian ligament, gravity and body posture.²³

One popular explanation of ovum pickup holds that the egg is grasped by a suction within the tubal lumen. This suction is created by a current resulting from ciliary movement of the tubal secretions and by segmental contractions from the ampulla to the isthmus. The ovum is thereby brought into the tubal lumen either by direct aspiration from the ovarian surface or by being drawn from the peritoneal fluid of the cul-de-sac into the tubal secretions.²³ This "vacuum cleaner" aspect of tubal physiology was experimentally demonstrated by the recovery of ovum-sized starch granules from the cervix on the day following their placement in the cul-de-sac.²⁴

The propulsion of the ovum from the fimbrial to the ampullary portion of the tube may result primarily from ciliary action. Segmental contractions of the ampulla and isthmus move the ovum down the remainder of the tube. These contractions are both peristaltic and antiperistaltic, and appear to be a typical smooth muscle response, analogous to those of the small intestine.²⁵ Most authors contend that of these two mechanisms of egg transport, the latter is by far the most important in the human.

Ovum transit through the tube takes three to four days in most species, including man. The normal pattern of progress is a very rapid passage through the ampulla to the ampullary-isthmic junction, where fertilization usually occurs. After a prolonged sojourn in this area, the egg moves rapidly through the isthmus to the isthmo-uterine junction, where it is again detained before entering the uterine cavity.²⁵

In an effort to question the importance to ovum pickup of suction caused by tubal peristalsis, Clewe and Mastroianni suture-ligated rat oviducts just proximal to the fimbrial end. They noted no impairment in the ability of the tube to pick up ova, and concluded that tubal suction is not essential to ovum pickup, at least in the rab-

bit, and that ciliary activity at the fimbria is sufficient to insure ovum pickup.²⁶

An interesting tubo-ovarian mechanism has been proposed by Decker after some eight years of culdoscopic observation of the pelvic organs. He noted that with the patient in the knee-chest position, the ovaries assumed one of three positions. In the first of these the ovaries and tubes hung free in the pelvis with the ovaries in close proximity to the tubal fimbria and with no evidence of disease. In the second position, the ovaries were adherent laterally in the pelvis, anterior and posterior to the broad ligament, with thin or obscured ovarian ligaments and with evidence of chronic inflammatory disease. The third position consisted of ovaries located against or near the uterine corpus, posterior to the broad ligament and just below the tube. There was no evidence of disease in this situation, and the ovarian ligament was short and thick with several fimbria in contact with the ovary. His theory proposed that the ovarian ligament contracts at or near the time of ovulation, thereby drawing the ovary to the posterior surface of the uterus just below the tube, in contact with its fimbriae. The close relation between the tubal ostium and the ovary, as the latter is drawn to the side of the uterus, is facilitated by the attachment of the fimbria ovarica to the lateral pole of the ovary. The ovarian ligament varied from 1.5 cm at the time of ovulation to 3.5 to 4.5 cm during the secretory phase of the cycle, with obvious changes in thickness.

Decker concluded that ovarian and tubal adhesions and other pathologic conditions, such as appendicitis, post partum or postabortal infections, tuberculous peritonitis, and endometriosis, interfere with this mechanism by fixing the ovaries in the pelvis. The result is delay or prevention of conception, even though the tubes may be patent.²⁷

Ovum pickup and transit through the tube, like the rest of reproductive physiology, is under some degree of hormonal control. Bilateral oophorectomy of animals following ovulation decreases the rate of transport significantly from the infundibulum to the ampullary-isthmic junction of the tube. Treatment of castrated female subjects with estrogen, however, restores the rate

of ovum migration to levels seen in ovulating animals. Estrogen, therefore, has a definite stimulating effect on the rate of ovum transport, probably by increasing the activity of ampullary musculature. Progesterone, on the other hand, depresses the activity of ampullary musculature and thus causes a prolongation of ovum transport time.²⁸ It is the relative levels of those two hormones that determine the rate of egg transport. Alterations in the normal speed of ovum migration in the human through the use of exogenous hormones may disturb the rigidly scheduled encounter of sperm and egg in the ampulla just after ovulation. Oral contraceptives may therefore have yet another mechanism by which they interfere with fertilization.

Summary and Comment

Since Gabriele Fallopio described the uterine tube in the sixteenth century, a considerable fund of knowledge about the basic tubal functions of ovum, sperm, and zygote transport and support, and sperm capacitation, has been accumulated.

The gross and microanatomy of the tube has been described in some detail. The development of tubal mucosa is greatest during the proliferative phase of the menstrual cycle, and regresses during the secretory phase and during pregnancy. Ciliogenesis by certain cells is stimulated by estrogen and inhibited by progesterone.

The mucosa of the uterine tube actively secretes enzymes, amino acids, carbohydrates and electrolytes. Estrogen augments tubal fluid secretion and progesterone exerts a negative influence on this process.

Spermatozoa depend upon tubal secretions for the substrates of their metabolism, which is significantly increased in rate while residing in the tubal lumen. Sperm capacitation occurs primarily within the tube, enabling spermatozoa to undergo the acrosome reaction and subsequent penetration of the ovum. Estrogen again stimulates this tubal function, while progesterone, which has little effect on capacitation by the tube, depresses it within the uterine cavity.

Ovum pickup from the ovary or peritoneal cavity, and its transport, result from a combination of ciliary motion and peristaltic contractions of tubal musculature, the latter mechanism being the most important. The rate of ovum transit is regulated by the various anatomic segments. This rate is increased by estrogen and decreased by progesterone through their respective effects on tubal musculature. The utero-ovarian ligament has been shown actively to contract during ovulation, thereby bringing the tubal ostium and ovarian surface in direct apposition. Disease processes disturbing this mechanism have been implicated to be direct causes of female infertility.

The understanding we now have of tubal physiology results from an impressive collection of investigative efforts. The clinical application of this knowledge to the fields of infertility and contraception is, however, only in its infancy. A few implications of the role of tubal physiology in these areas are offered here.

Evaluation of the "tubal factor," considered to be responsible for 30 percent of infertility, by tubal insufflation, hysterosalpingography, culdoscopy, and laparoscopy, is a basic part of the female infertility workup. All of these procedures, however, concern themselves with the determination of tubal structure within the pelvis. If tubal anatomy is judged to be normal by these tests, the assumption is usually made that tubal function is normal. If one considers the complex physical and chemical tubal mechanisms presented in this paper, however, this assumption can no longer be accepted as being completely valid. The fact that a tube is patent, for example, offers no guarantee that its mucosal secretions are normal, that its cilia are functioning, or that its lumen can capacitate sperm. Continuing, most tubal surgery is directed at correcting intraluminal and external abnormalities in tubal anatomy. No surgical technique can regulate tubal secretion, improve ciliogenesis, or stimulate tubal peristalsis. It is not suggested here that surgical correction of tubal occlusions or immobility is ineffective. Such procedures must certainly improve tubal function to some degree, but the contention is that they succeed only when tubal function is grossly disturbed by overt anatomical distortion.

When one considers the delicate hormonal controls over tubal activity, it is not difficult to reason that any derangement of the hypothalamic-pituitary-ovarian axis might seriously impede the tube's role in fertility. Medical or surgical correction of hormonal imbalance in the female must afford some improvement to tubal function.

An understanding of tubal physiology is relevant to both the procurement of conception and to the science of contraception. An obvious example is interruption of ovum transport by ligation of the tubal lumen. The effects of cauterization on tubal mucosa and musculature are more subtle and complex. Exogenous hormones, such as oral contraceptives, significantly alter tubal secretion, ciliary development, peristaltic motion, and capacitation of sperm. Alterations in these processes must result in an inefficient tubal mechanism.

A primary intent of this paper was to refute the commonly held belief that the uterine tube is merely a conduit between the ovary and the uterine cavity. The physiology of the tube is, in fact, so complex that it makes one wonder that fertilization occurs at all. The fact that it does in most women only serves to increase one's appreciation for the myriad of tubal structural, functional, and biochemical interactions.

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Contraindications: In individuals with history of allergic reaction to penicillins.

WARNINGS: SERIOUS AND OCCASIONALLY FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS REPORTED IN PATIENTS ON PENICILLIN THERAPY. ALTHOUGH MORE FREQUENT FOLLOWING PARENTERAL THERAPY, ANAPHYLAXIS HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. MORE LIKELY IN INDIVIDUALS WITH HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. BEFORE THERAPY, INQUIRE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS OR OTHER ALLERGENS. IF ALLERGIC REACTION OCCURS, INSTITUTE APPROPRIATE THERAPY AND CONSIDER DISCONTINUANCE OF AMOXICILLIN. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. ADMINISTER OXYGEN, INTRAVENOUS STEROIDS AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS INDICATED.

Usage in Pregnancy: Safety in pregnancy not established.

Precautions: As with any potent drug, assess renal, hepatic and hematopoietic function periodically during prolonged therapy. Keep in mind possibility of superinfections with mycotic or bacterial pathogens; if they occur, discontinue drug and/or institute appropriate therapy.

Adverse Reactions: As with other penicillins, untoward reactions will likely be essentially limited to sensitivity phenomena and more likely occur in individuals previously demonstrating penicillin hypersensitivity and those with history of allergy,

asthma, hay fever or urticaria. Adverse reactions reported as associated with use of penicillins: *Gastrointestinal:* Nausea, vomiting, diarrhea. *Hypersensitivity Reactions:* Erythematous maculopapular rashes, urticaria. **NOTE:** Urticaria, other skin rashes and serum sickness-like reactions may be controlled with antihistamines and, if necessary, systemic corticosteroids. Discontinue amoxicillin unless condition is believed to be life-threatening and amenable only to amoxicillin therapy. *Liver:* Moderate rise in SGOT noted, but significance unknown. *Hemic and Lymphatic Systems:* Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, agranulocytosis. All are usually reversible on discontinuation of therapy and believed to be hypersensitivity phenomena.

Dosage: *Ear, nose, throat, genitourinary tract, skin and soft tissue infections*—Adults: 250 mg every 8 hours. Children: 20 mg/kg/day in divided doses every 8 hours; under 6 kg, 0.5 ml of Pediatric Drops every 8 hours; 6-8 kg, 1 ml of Pediatric Drops every 8 hours. *Lower respiratory tract infections and severe infections or those caused by less susceptible organisms*—Adults: 500 mg every 8 hours. Children: 40 mg/kg/day in divided doses every 8 hours; under 6 kg, 1 ml of Pediatric Drops every 8 hours; 6-8 kg, 2 ml of Pediatric Drops every 8 hours. *Gonorrhea* (acute uncomplicated anogenital and urethral infections)—Males and females: 3 grams as a single oral dose. **NOTE:** Children weighing more than 8 kg should receive appropriate dose of oral suspension 125 mg or 250 mg/5 ml. Children weighing 20 kg or more should be dosed according to adult recommendations.

Note: In gonorrhea with suspected lesion of syphilis, perform dark-field examinations before amoxicillin therapy and monthly serological tests for at least four months. In chronic urinary tract infections, frequent bacteriological and clinical appraisals are necessary. Smaller than recommended doses should not be used. In stubborn infections, several weeks' therapy may be required. Except for gonorrhea, continue treatment for a minimum of 48-72 hours after patient is asymptomatic or bacterial eradication is evidenced. Treat hemolytic streptococcal infections for at least 10 days to prevent acute rheumatic fever or glomerulonephritis.

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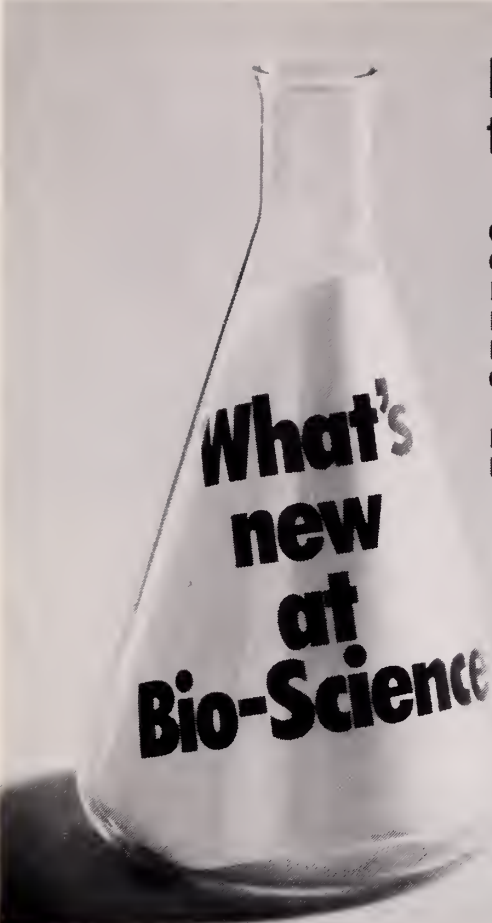


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This report concerns a patient who presented with vague symptoms which were initially diagnosed as cholecystitis. These symptoms and signs eventually localized to the chest. Despite confusing clinical findings, the diagnosis of amebiasis was established, and appropriate therapy was instituted. The patient had previously spent five years in South Vietnam. A high index of suspicion for this disease is indicated in patients with a history of service in Southeast Asia.¹

Pleuropulmonary Amebiasis

Edwin S. Wilson, M.D./Mount Holly

Amebiasis is the clinical syndrome produced by infection with the pathogenic amoeba, *Entamoeba histolytica*. The intestinal form is encountered most frequently, and may occur in acute or chronic form. Acute amebic dysentery presents with the explosive onset of headache, prostration, chills, fever, abdominal pain, and bloody diarrhea. The chronic form of intestinal amebiasis presents a variable clinical picture, and the carrier form may be entirely asymptomatic.^{2, 3}

Amebic liver involvement is the most common extraintestinal manifestation, and may present as amebic hepatitis or amebic hepatic abscess. This extension is secondary to proteolytic digestion of cecal mucosa and submucosa by the parasite. Trophozoites subsequently invade submucosal mesenteric venules, and are transported to the liver via the portal vein. This complication may occur during the acute phase of the illness or during an asymptomatic remission period. After hepatic involvement, pleuropulmonary extension is the second most common manifestation of amebiasis outside the intestine.⁴ Patients with pleuropulmonary amebiasis may present with symptoms referable only to the chest; when the patient is seen for the first time abdominal symptoms may be absent or forgotten.

Case Report

A 49-year-old engineer was admitted to the hospital as an emergency patient on October 20, 1973; he had a four-day history of pain in the right upper quadrant of the abdomen. Temperature on admission was 38.3°C, but vital signs were otherwise within normal limits. Physical examination revealed mild right subcostal tenderness, but no organ enlargement. Bowel sounds were normal. Cardiac rhythm was regular, and normal breath sounds were heard

bilaterally. Admission chest x-ray was normal. White blood count was 21,000 cells per cu. mm. with 79 percent neutrophils. Alkaline phosphatase was slightly elevated, and there was a mild increase in total bilirubin to 1.3 mg. per 100 ml.

A tentative diagnosis of cholecystitis was made and therapy with intravenous fluids and antibiotics was begun. By the following morning, the patient was more seriously ill and was taken to the operating room with the preoperative diagnosis of cholecystitis. Cholecystogram was deferred due to the severity of the clinical course. At surgery, the gallbladder was mildly inflamed, but not sufficiently so to explain the patient's clinical course. The abdomen was carefully evaluated, including exploration of the subphrenic space. No abnormality was found; the liver appeared grossly normal. Because of the mild changes within the gallbladder, cholecystectomy was performed.

Following surgery, the patient continued to have fever to 39.4°C. Two days following surgery, cough and mild dyspnea were apparent and physical examination of the chest revealed dullness at the right base, decreased breath sounds, and inspiratory rales. Chest x-ray on October 24, 1973 disclosed a right lower lobe infiltrate and five days later chest x-ray, with fluoroscopy, showed elevation of the right hemidiaphragm, right lower lobe consolidation, and right pleural effusion. Liver scan performed on October 30, 1973 with Tc99 Sulfur Colloid, demonstrated the presence of two large filling defects within the right lobe of the liver.

Abdominal exploration was performed on October 31, 1973 and a large subphrenic abscess was encountered. This was irrigated, and the two hepatic abscesses were aspirated and cultures obtained. Flagyl® in doses of 500 mg. every eight hours was administered. After an initially stormy course, the patient responded and was discharged from the hospital on November 23, 1973. During this convalescent period, an indirect hemagglutinin titer for amebiasis of 1:4096 was reported (normal less than 1:128). All cultures obtained during hospitalization were negative, including those obtained directly from the abscess cavities.

Discussion

Amebiasis has a world-wide distribution, with an estimated incidence of eight percent within the United States.² The disease is due to infection with *Entamoeba histolytica*, a pathogenic amoeba which has a number of stages in its life

*This report is from the Department of Radiology, Burlington County Memorial Hospital, Mount Holly.



Figure 1 — Frontal roentgenogram of the chest reveals slight elevation of the right hemidiaphragm. Lungs are clear. There is no pleural effusion.



Figure 2 — Frontal chest roentgenogram nine days after admission reveals apparent elevation of the right diaphragm and right lower lobe consolidation.



Figure 3 — Lateral decubitus chest film obtained at same time as Figure 2. This reveals the presence of a large right pleural effusion.

cycle, including trophozoite, precyst, cyst, and metacystic trophozoite. The trophozoite is the active, feeding form and produces tissue invasion by the release of proteolytic enzymes. Ingestion of the cyst will produce clinical disease, but the trophozoite is destroyed by hydrochloric acid and peptic digestion in the stomach. The cysts of *Entamoeba histolytica* may remain viable in water for up to thirty days, but are destroyed by temperatures over 50°C.

Ingestion of the cyst may produce infection through release of the trophozoite during passage through the small intestine of the host. The trophozoite, the tissue-destroying form of the protozoan, multiplies within the cecum and produces proteolytic digestion of the mucosa and submucosa. Because the muscularis mucosae form a relative barrier to their penetration, large flask-like ulcers result. The cecum and ascending colon are involved in over



Figure 4 — Liver scan performed with Tc-99m sulfur colloid reveals the presence of two large cavities within the liver.

70 percent of cases, with the recto-sigmoid the next most favored site.² When digestion of the walls of mesenteric venules occurs, this provides the eventual pathway for hepatic and pulmonary spread via the portal vein and inferior vena cava. Once within the liver, the trophozoites penetrate the portal sinusoids and produce amebic hepatitis and/or amebic hepatic abscess.

Pleuropulmonary extension of disease occurs in about 20 percent of patients with amebic liver abscess.² Intrathoracic manifestations include pneumonic consolidation, lung abscess, serous effusion, empyema, broncho-hepatic fistula, and pericarditis.⁴ The intrathoracic spread of amebiasis may occur by one or more of several theoretical mechanisms:

1. Rupture of an amebic hepatic abscess directly through the diaphragm.
2. Transdiaphragmatic spread of amebic abscess or hepatitis by means of lymphatic channels.
3. Embolic dissemination of colonies of *E. histolytica* to lung and/or pleura from sites within colon or liver.
4. Inhalation of cysts of *E. histolytica*.

Clinical findings in patients with amebiasis depend upon the site of involvement, as well as the clinical stage of the disease. Acute amebic dysentery may produce malaise, fever, chills, abdominal pain, headache, and bloody diarrhea. However, patients with chronic dysentery may have only occasional diarrhea, while some carriers are entirely asymptomatic. Patients with pleuropulmonary disease, therefore, may or may not give a history of previous abdominal symptoms. Intrathoracic extension of the disease may produce fever, chills, pleuritic chest pain, hemoptysis, and expectoration of a characteristic chocolate-colored or "anchovy-paste" material, if extensive tissue necrosis has occurred.^{4, 5, 6} Hepatomegaly and right upper quadrant tenderness are important physical findings when present; pulmonary consolidation and pleural effusion almost invariably occur on the right side. On rare occasions, purulent pericarditis may produce pericardial tamponade.^{5, 7}

Laboratory findings are variable, but leukocytosis has been a fairly consistent finding in the reported cases. In contrast to disease with

other parasites, eosinophilia is not common, being seen in less than 25 percent of cases.⁴ The isolation of *E. histolytica* is notoriously difficult to achieve from stool, sputum, and pleural fluid in patients with pleuropulmonary amebiasis.^{4, 5, 8} Serologic tests are helpful when positive: the serum complement fixation and hemagglutinin tests may provide the only clue to the diagnosis (as demonstrated by this patient). Although a negative test does not exclude the diagnosis, the studies are essential. Acute and convalescent serum should be drawn on all patients with liver abscess, and should be considered in certain "high-risk" patients with obscure right upper quadrant findings or with undiagnosed pulmonary infiltrates near the right diaphragm. "High-risk" patients are those with previous travel or service in regions where amebiasis is endemic, such as South Vietnam.

Radiographic features of the disease are not pathognomonic, but certain combinations of signs may suggest the diagnosis. These features are diaphragmatic elevation, pleural effusion, lower lobe consolidation, and lung abscess.^{1, 9} Elevation of the right hemidiaphragm usually indicates the presence of an intrahepatic abscess, but may also occur with subphrenic abscess and atelectasis of the right lung. The right lobe of the liver is typically involved due to the portal venous flow from the cecum and right colon. Likewise, the anterior basilar segment of the right lower pulmonary lobe is characteristically diseased, due to proximity to the dome of the diaphragm and right lobe of the liver. If an abscess forms within the lung which communicates with the bronchial tree, an air-fluid level will be visualized on the erect or decubitus films of the chest.

The diagnosis of amebiasis can be established with absolute certainty only by the isolation of the protozoan from sputum, pleural fluid, stool, or tissue specimen. In most patients with amebiasis, this is not possible, so the diagnosis is most frequently established by indirect means. Isolation of cysts of *E. histolytica* from the stool of patients is one such method, but this occurs infrequently in patients with pleuropulmonary amebiasis.^{1, 4, 6, 7, 8} In this patient, as in patients previously reported,¹ the presence of an abnormal liver scan may be an important diagnostic

clue. Liver scan should be seriously considered in patients with atypical gallbladder symptoms, especially when the cholecystogram is equivocal and the patient gives a history of travel in an endemic area of the world. Once the diagnosis is entertained, serum for appropriate serologic studies should be obtained. Positive titers against *E. histolytica* are an indication of disease, but negative studies do not exclude the diagnosis.^{2, 3}

Treatment of the disease is primarily medical, but some selected patients will require surgical intervention. Over 90 per cent of patients will be cured by appropriate medical treatment but surgical drainage of resistant empyema may occasionally be necessary.^{2, 5} Medical therapy for hepatic disease is appropriate, but in the difficult case surgical intervention for diagnosis may be required.

Summary

This paper reports a patient who was operated upon with the presumptive diagnosis of cholecystitis. However, at surgery the appearance of the gallbladder did not fully explain the patient's symptoms and the liver was normal to inspection. Following surgery, the patient was febrile with cough, dyspnea, and mild chest pain. Plain x-ray films of the chest demonstrated right lower lobe infiltrate with effusion and elevation of the right hemidiaphragm. These findings which raised the possibility of amebiasis, were further strengthened by the patient's history of five years served in South Vietnam. Liver scan revealed two large cavities within the liver; serologic studies confirmed the diagnosis of

amebiasis. Medical therapy was begun following surgical drainage for diagnosis and the patient was discharged three weeks following admission.

Previous articles have stressed the need for a high index of suspicion for this disease, especially in civilians and military personnel returning from Southeast Asia.¹ Indeed, this disease should be routinely included in the differential diagnosis of diseases occurring in patients traveling through endemic areas. In addition to the importance of a good history, this patient also illustrates the importance of the liver scan in selected patients, as well as the value of appropriate serologic studies.

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Current standards of prenatal care dictate that special attention be paid to the fetus at high risk because of a number of obstetric conditions. Easy access to the fetus is provided via amniotic fluid, which may be obtained during pregnancy by transabdominal tap. Analysis of amniotic fluid is valuable in determining maturity of the fetus, in evaluating whether a fetus is compromised by hemolysis or hypoxia, and in determining whether a fetus is affected by a genetic disease for which it is known to be at risk.

Amniotic Fluid Analysis in Prenatal Diagnosis

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Amniocentesis, or insertion of a needle into the amniotic sac, was first described in 1930 as part of the procedure of amniography for placenta localization.¹ Because amniocentesis was thought to involve undue risk to continuation of pregnancy, it was not commonly used until the demonstration in the 1950's by Bevis² that levels of blood pigments in the amniotic fluid could be used to evaluate many factors relating to the fetus. The value of amniotic fluid analysis depends upon the fact that there is a significant fetal contribution to its composition, including a daily production of approximately five hundred milliliters of urine by the term fetus, secretions from the tracheo-bronchial tree, and desquamation of epithelial cells from the fetal skin. In addition, the fetus swallows about five hundred milliliters of amniotic fluid per day, effectively removing some of those substances contained therein.

Amniocentesis must be performed at such time as there is sufficient volume present to allow easy and safe removal of adequate fluid for diagnostic purposes. The earliest recommended is approximately 15 weeks of gestation, at which time amniotic fluid volume ranges from 125 to 150 ml. From then until 37 weeks there is a progressive increase in volume, ultimately to

about 1000 ml. Beyond 37 weeks, there is a gradual decrease and in the post-term pregnancy there may be little or no fluid, making successful amniocentesis difficult.

Technique

The technique is relatively simple. A sterile #20 or 22 spinal needle, three and a half inches in length is used. Prior placental localization by ultrasound is advised if available. If not, sites thought to be free of placental implantation are chosen. If relatively early in pregnancy, a point midway between the symphysis and fundus in the midline is used. Later, the tap is made at the site of the rather large pocket of amniotic fluid that usually exists at the nape of the neck or at the location of the fetal small parts. If neither is easily felt, this may indicate that the placenta is implanted rather low on the anterior wall of the uterus, and it is best to manually elevate the presenting part out of the lower uterus and make a suprapubic puncture. Unless the patient is obese, amniocentesis is approximately 90% successful at the first attempt and virtually 100% at the second attempt.

Complications

Complications are relatively rare, but important. Potential maternal problems include perforation of viscus adherent to previous abdominal scar, hemorrhage, intrauterine infection and isoimmunization. Potential fetal complications include abortion, exsanguination from trauma to a fetal vessel of the cord or placenta, and direct trauma from the needle. Because of

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these potential hazards, amniocentesis should not be undertaken lightly, but should be done only when justified by the need for the specific information available. When indicated, it is an extremely useful procedure, easily performed in the office, which provides valuable information for treating the intrauterine patient.

Applications

Current applications of amniocentesis include evaluation of the extent of fetal involvement by hemolytic disease, determination of fetal maturity, evaluation of fetal well being, and prenatal diagnosis of hereditary disease. Each will be discussed.

Blood Group Isoimmunization

Although Rh(D) isoimmunization is the most common cause of erythroblastosis fetalis, any of the red cell antigens other than Lewis may be involved. Accordingly, amniotic fluid evaluation should be considered whenever antibodies to any blood factor are demonstrated at routine prenatal antibody screening. Such evaluation has resulted in reduced perinatal mortality from approximately 25 to 30 percent, with management based solely upon past obstetric history, level of antibody titers, presumed zygosity of the husband, and menstrual history, to approximately 10 percent. After amniotic fluid evaluation, either intrauterine transfusion or early delivery may be indicated by bilirubin levels.

Initial tap should be at approximately 28 weeks, except in those pregnancies in which there is a previous history of severe erythroblastosis fetalis, when it should be done as early as the 22nd week. Bilirubin levels are measured by elevation of the optical density at 450 micra. One must be careful to protect the amniotic fluid from exposure to light which causes decomposition of bilirubin. The fluid is immediately centrifuged at 2500 rpm for 10 minutes to prevent lysis of any red cells and a continuous scan from 350 to 700 micra is performed. Interpretation is usually based upon the zones of Liley or the criteria of Freda. Liley's system is based upon a prediction of the hemoglobin at birth, should that fetus be delivered within one week. Because the condition of the fetus changes, repeated taps

must be made at least every other week. Freda's system is based upon the prediction of the ability of that fetus to survive *in utero*, from which one determines subsequent management. For an in-depth discussion, one should consult the original papers.^{3, 4}

Determination of Fetal Maturity

Because of the contribution of various fetal organ systems to the amniotic fluid, numerous tests of fetal maturity have been developed. Each test is based upon the maturation of a specific organ system. However, since each system does not necessarily mature at the same rate, there may be differences in interpretation depending upon the method used.

Staining of fetal cells by Nile blue sulfate, with subsequent microscopic examination for "orange" cells, was one of the earlier methods. Two drops of 0.1 percent Nile blue sulfate are added to one drop of amniotic fluid, the slide is examined, and at least 200 cells are counted. With increasing maturation of the fetus, there are increasing percentages of orange cells among the more common large blue staining cells. The orange material is apparently neutral fat secreted by the fetal sebaceous glands. It has been demonstrated that usually more than 20 percent orange cells indicate virtually no chance of the fetus being premature.⁵ However, this has not proved to be a universal finding and may occasionally lead to misinterpretation. Some term babies have virtually no orange cells and occasional prematures have greater than 20 percent. Accordingly, although this is an easily performed test which is reproducible by different examiners, it is not recommended.

Amniotic fluid creatinine levels have been used to predict fetal maturity. It has been demonstrated that levels of 2 mg. per 100 ml, or greater, indicate a mature fetus at the 95 percent confidence levels.⁶ This is true only if there is no elevation of maternal serum creatinine levels, and may not be accurate if there is intrauterine growth retardation. Creatinine probably reflects both fetal urination and muscle mass, the former measuring maturity of fetal kidneys.

The best evaluation of fetal maturity currently available is the measurement of the amniotic

fluid lecithin/sphingomyelin ratio. This is a test of the amount of surfactant produced by the Type II aveolar cells of the fetal lung, and subsequently excreted into the amniotic fluid.⁷ Sphingomyelin levels are relatively constant throughout pregnancy, whereas at about 35 to 36 weeks, there is a surge in lecithin. During 12 to 24 weeks, the L/S ratio is less than one. Between weeks 22 and 24, it increases to approximately one. At 31 to 32 weeks, it is 1.2, and finally at 35 to 36 weeks it reaches a level of two or greater. The ratio is measured by estimation of sizes of spots on thin layer chromatography. Prolonged standing, blood fluid, or meconium may make the test invalid.

A simple bedside test, the "shake" test or foam test, may give an estimation of the amount of surfactant present in amniotic fluid.⁸ This depends upon the ability of lecithin to generate a stable foam in the presence of 95 percent ethanol. Progressive dilutions of amniotic fluid with saline are made. Each is mixed with one milliliter of 95 percent ethanol, shaken for 15 seconds, and allowed to sit for 15 minutes. If a layer of bubbles persists around the meniscus in a dilution of 1:2 (0.5 ml of amniotic fluid and 0.5 ml of normal saline), the fetus is considered mature and is at virtually no risk for hyaline membrane disease. It is most important that volumes are accurately measured and that clean glassware is used.

Bilirubin, as measured in Rh isoimmunization, may also be used as a determinant of fetal maturity. This virtually disappears from the amniotic fluid at approximately 36 weeks. There are artifacts, including phenothiazides, maternal hyperbilirubinemia from hepatitis, hemolytic anemia, or cholestasis, which may cause persistence of bilirubin beyond the usual time. Such circumstances render the test useless. Osmolality and total protein have also been evaluated as methods of determining fetal maturity, but neither has proven to be worthwhile because of wide scatter of normal results at term.

Evaluation of Fetal Well-Being

The fetus responds to hypoxia by shunting blood away from the gastrointestinal tract to more vital organs, such as kidney and brain. This

results in hyperperistalsis of the gut and a loss in vagal tone, with passage of meconium by the fetus. In patients felt to have high risk of fetal hypoxia, such as in post-datism, the presence of meconium may be considered as a possible sign of fetal distress and may indicate the need to terminate pregnancy or to re-evaluate placental function by other methods. Although amniocentesis may be performed to determine whether meconium-stained fluid is present, abdominal tap may be avoided by use of amnioscopy. This is insertion of an instrument through the slightly dilated cervix. The scope contains a light source, which illuminates the amniotic fluid. The light rays from the amnioscope, which illuminate the amniotic fluid are reflected by either fetal scalp or by particles of vernix within the amniotic fluid. Amnioscopy may be performed in the office, although a slight risk of rupture of membranes or bleeding from an unsuspected placenta previa exists. Saling⁹ has demonstrated that if amniotic fluid is clear, the fetus is virtually certain not to die *in utero* during the next 48 hours, barring unexpected obstetric accidents. Since the post-term fetus may develop distress at any time, evaluation must be done about every other day; this gives amnioscopy definite advantages over repeated invasion of the amniotic sac by amniocentesis.

Estriol in amniotic fluid seems to reflect the estriol in the fetal compartment and correlate well with fetal weight and status.¹⁰ It is not subject to the same artifacts as are measurements of serum and urine estriol. Unfortunately, estriol determinations must be done serially to be of value, making amniotic fluid determinations impractical. Usually urinary or plasma determinations are adequate. The one situation in which amniotic fluid levels correlate better with fetal status than urinary or plasma levels is severe erythroblastosis fetalis; but in such instances bilirubin measurements give excellent correlation with fetal status.

Thyroid hormones have been measured in amniotic fluid and it is possible to predict the thyroid status of a fetus. Normal protein-bound iodine in amniotic fluid varies from 0.7 to 2.2 mcgm/100 ml with a plateau reached at about 20 weeks of gestation, at which time the feedback mechanism between thyroid hormone and TSH is probably well established.¹¹

Alpha fetoprotein, specifically made by the fetus, has recently been shown to be of value in mid-trimester prediction of central nervous system defects of the fetus.¹² Normal values of amniotic fluid alpha fetoprotein are less than 2 mg/100 ml, whereas in the presence of central nervous system anomalies one often finds markedly elevated levels in the mid trimester. This is not specific for CNS lesions, but may be found also in hydrops fetalis or fetal distress; elevation simply alerts the obstetrician to the need for further evaluation. Its use should be considered when high risk is thought to exist because of previous history of central nervous system anomalies.

Prenatal Diagnosis of Hereditary Disease

Currently, more than forty specific diseases may be diagnosed before birth. These include chromosomal abnormalities as well as sex-linked or autosomal recessive inborn errors of metabolism. Diagnosis is based upon the premise that fetal cells desquamated *in utero* and subsequently grown in tissue culture retain *in vitro* the same characteristics found *in vivo*. In women at high risk for a fetus with Down's syndrome, such as older women, karyotypes of fetal cells will confirm or rule out the diagnosis. Diagnosis of biochemical abnormalities is based either upon absence of a normal constituent of amniotic fluid or upon the accumulation of a metabolic byproduct. An example of a diagnosable metabolic disease is Tay-Sachs disease, in which there is a demonstrable deficiency of the enzyme hexosaminidase A in the amniotic fluid cells. For a complete discussion of prenatal diagnosis of genetic disease, the reader is referred to an appropriate reference.¹³

Before attempting prenatal genetic diagnosis the patient should be thoroughly apprised of the risks and limitations of the procedure. She must realize that even in the best laboratories, there are occasional failures in tissue culture from amniotic fluid and that such diagnostic tests are not for screening, but are specific tests for a disease for which her fetus is known to be of high risk. Since the fetus may be affected by many other conditions, a normal finding in amniotic fluid cells in no way guarantees a normal baby.

Summary

Currently, amniotic fluid which is obtained by amniocentesis, is used for a variety of prenatal diagnostic procedures, allowing for proper timing of delivery, for evaluation of the status of the fetus, and for prenatal diagnosis of genetic defects.

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Allergic reactions to stinging insects are frequent and at times life threatening. Prophylaxis using whole body extract immunization has proved 95 percent effective in diminishing the reaction to subsequent stings, according to many reports. When available in the future, specific pure venom extracts may prove to be even more effective. Methods of avoiding stings and the treatment of the acute reactions from them are discussed.

Allergic Reactions to Stinging Insects: A Review

Michael Diamond, M.D./Union
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In the late summer and early fall of 1974, a rash of emergency visits caused by allergic reactions to stinging insects occurred. Most patients responded well to the emergency treatment of their symptoms, but at least 40 people a year in the U.S.A. alone, die as a result of insect venom. Many people feel that the actual number is much higher because many deaths occurring outdoors which are classified as heart attacks might in reality be allergic reactions to insect stings. The number of people who die from insect venom is far greater than the mortality from snake or spider venom.¹

History's first recorded death from stinging insects was that of an Egyptian Pharaoh Menes who died of a wasp sting. The first recorded death in the U.S. occurred in Wadsworth, Vermont in 1811.

Because of the magnitude of this problem, the New Jersey Allergy Society considers a review warranted. We address ourselves to the following problems:

1. What insects sting?
2. What symptoms occur secondary to stings and which of these symptoms are allergic?
3. How does the physician determine if an allergic reaction has taken place?
4. What materials are used for skin testing? How is it performed and what information is obtained?
5. Which patients should receive allergic hyposensitization or immunization treatment?
6. How effective are these injections and how long should they be given?

7. What can the patient do to avoid being stung?

8. What emergency steps should the patient and the physician take if the patient is stung?

Reactions to Insect Stings

Allergic reactions to insects can occur from the inhalation of debris from mites (which may be the major antigen of house dust) or the May fly.² They can occur from saliva injected by biting insects such as the mosquito. However, this review will consider only those reactions occurring from the injection of venom by stinging insects.

Insects forming the order Hymenoptera, i.e., honey bees, wasps, yellow jackets, hornets, and ants inject venom when stinging a person. The imported fire ant, which is not found in the northeastern United States, is the only ant which gives serious reaction.³

The venom contains many vaso-active substances including phospholipase A (also thought to be a potent antigen), mellitin, acetylcholine, histamine and kinin-like materials.⁴ The injection of these substances causes local pain and swelling in all persons, however some people are allergic to the antigens in the venom and may develop reactions which vary from local swelling, 24 hours after the sting, to acute anaphylaxis and death within seconds or minutes.

It is usually impossible for the victim to tell which insect stung him, unless he knows the habits of the different Hymenoptera. The wasp builds its nest of mud or paper in trees, under the eaves of houses and sometimes in sheds. Unless you bother it, it won't bother you. Hornets and yellow jackets closely resemble each other, ex-

*This study is a cooperative effort under the aegis of the New Jersey Allergy Society. Reprints may be requested of Dr. Diamond, 381 Chestnut St., Union, 07039.

cept for an extra black band on the hornet between the eyes and the mandible. However, the hornet locates its nest of paper and mud high, while the yellow jacket locates its nest in the ground. The yellow jacket is a very irritable insect and will attack without provocation. Frequently, one will see them near wastepaper baskets and food stands, while the honeybee nests under the floor boards or in hollow trees. Interestingly, only the female honeybee leaves a stinger in its victim.⁵

Not all symptoms, however, seen after a sting are allergic in nature. The small local swelling pain, heat, and rubor is a lymphadenitis which is mistakenly thought to be due to secondary infection. The treatment for these problems is local anti-inflammatory medications. Many allergists feel that reactions which extend beyond one joint or recurrent stings which cause increasingly large reactions should be considered allergic,⁴ and may eventually lead to anaphylactic-type systemic reactions.

Another type of non-allergic reaction, which is equally as dangerous as anaphylaxis, is that caused by stings from a large number of insects, such as the patient encounters who gets in a nest of bees. Here the quantity of vasoactive substance injected is so great that it causes a generalized reaction that looks like and should be treated in the same manner as anaphylaxis.

The Allergic Reaction

The allergic reaction is the one we are most interested in in this review. This is caused by the patient having attached to his mast cells an antibody of the IgE class which has been produced in the past as a response to antigens in the venom (sting) of Hymenoptera. On subsequent exposure (sting), the antigen reacts with the IgE bound to the mast cell, causing the cells to degranulate and release vaso-active substances, which give the clinical symptoms of anaphylaxis.⁶ The symptoms usually occur within the first hour after the sting, however, in rare cases they have occurred up to 24 hours after the sting. Symptoms can vary from a feeling of anxiety or syncope which is difficult to evaluate, to generalized hives, angio-edema, difficulty breathing, laryngeal edema, wheezing, shock and even death.

Statistics of the Insect Committee of the American Academy of Allergy show that 69 percent of autopsied patients who died of insect stings succumbed from respiratory problems; 12 percent died from anaphylactic reactions; 12 percent had vascular pathology, and 7 percent neurologic disorders. Fifty-nine percent of the deaths were within one hour, 22 percent were within the one to six-hour period; 7 percent between six and ninety-six hours and 9 percent after four days.

Allergic reactions to Hymenoptera occur to the same degree in patients who have a history of other allergies, as those who do not have such a history.

It is generally considered that there are four types of immunological reactions:

Type I — IgE mediated, as for example, the anaphylactic type discussed above; this is most common in insect sting.

Type II — a type which involves cell destruction by the antigen reacting with the cell-bound antibody; it is usually IgG mediated and involves the use of complement — as in hemolytic anemia.

Type III — Immune Complex disease which is due to a circulating complex of antigen-antibody aggregates. These complexes may fix complement with the clinical picture of inflammation or vasculitis. Serum sickness reactions are type III as is vasculitis, arthritis, and nephritis.

Type IV — Delayed or cellular reactions which are mediated by the small lymphocyte and its lymphokines. It too can lead to cytotoxicity and local and general delayed tissue damage.

All of these types can be seen in variations of immunological reaction to severe insect stings; the most common is Type I.

Other less common reactions, which are immunologically based, also occur. Serum sickness-type symptoms can occur approximately one to three weeks after the bite. They consist of recurrent hives, swollen joints, fever, occasionally cardiac symptoms, and sometimes nephritis. The symptoms involved here are due to antigen, IgG antibodies, along with complement. Occasionally, six to twenty-four hours after the sting, reactions involving the nervous system, which may include cerebral symptoms, neuromyelitis optica or ascending neuritis, have been reported.⁶

Diagnosis

The most important factor in determining if an allergic reaction has taken place is history. If a patient tells the physician that he has been bitten and complains of symptoms other than the normal local swelling which is expected after a sting, an immunological reaction should be suspected. Physical examination will reveal signs related to the symptoms. An unconscious patient, found outdoors in the warm months with symptoms suggestive of anaphylaxis, may be considered as possibly having had a reaction to a Hymenoptera sting.

Allergy testing should be performed with extreme caution at least three weeks after the anaphylactic reaction has taken place, since there is often a period of non-reactivity after a reaction. Initial testing may be done by scratch technique with 1 to 100,000,000 dilution using equal parts of whole body extract of bee, wasp, and yellow jacket and hornet. If no local reaction occurs, intradermal tests may be started with the same dilution. Serial tests using ten-fold increases in dilutions for each new test should be done until a positive skin test is obtained, or a negative test to 1 to 100 dilution is reached. Severe reactions have been reported with tests of a 1 to 10,000,000 dilution in highly sensitive patients. Because of this, we suggest testing be done only by experienced physicians. A test is considered positive when a wheal of 8 mm. with a surrounding flare is obtained.

The value of testing is to determine the starting dose of extract to be administered for desensitization. Patients are occasionally seen who have negative skin tests and yet have well documented anaphylactic reactions. The reason for this is not clear. Studies are now being done using pure insect venom rather than whole body extracts which may shed light on this problem. However, this venom is not commercially available.⁷

Treatment

For the present, the Insect Committee of the American Academy of Allergy feels that all patients who give a good story of anaphylaxis from Hymenoptera should be treated with available antigen even if skin tests are negative.⁸

It is also felt that any large local reaction which extends beyond one joint probably is allergic in nature and should be treated.

Once a positive skin test is obtained the starting dose should be 0.1 cc of a concentration 10 times as diluted as the positive skin test. Immunization should be started on a once a week basis until a dose of 0.20cc of 1 to 10 solution, (approximately the amount of venom found in two stings) is completed. The period between desensitization injections should then be increased so that the patient receives injections once every four weeks for one year. After that attempts should be made to increase the length between injections to six to eight weeks, if possible.

The Insect Committee reports that 95 percent of treated patients have no reaction or a decrease in the intensity of reaction with subsequent stings. However, 63 percent of the untreated patients also had milder reactions on subsequent stings.² There are many possibilities to explain this. The most obvious is that the patient was stung by a different insect. He may also have a spontaneous loss of allergy. This has been shown to occur in some people who have had reactions to penicillin, but were able to tolerate penicillin years later.¹⁰

We feel that all patients with severe reactions should be treated, since there is no way at present of selecting the 63 percent who improve without treatment. There have been four deaths reported in patients who were treated but stopped desensitization after several years.¹⁰ Because of this, the present recommendation is to continue treatment indefinitely.

Since there is approximately a five percent failure rate from hyposensitization treatment with whole body extract, pure specific venom, which may prove to be more effective, is being studied.

Treatment failures have been reported with whole body insect treatments which have been closely studied. Sabatra, *et al.*¹¹ recently reported a beekeeper's wife who experienced anaphylaxis on being challenged after nine months of whole body extract immunotherapy. This patient was treated with pure venom of the

bee extracted and administered parenterally in increasing daily doses until the equivalent of one venom sac was given each day. With this treatment there was a fall in venom specific IgE titer in the patient's serum and a rise in the level of IgG blocking antibody. The patient at this point was challenged again without a reaction.

The future of insect sting hyposensitization treatment will probably be immunization by means of a mixture of pure venoms of the various hymenoptera. This is not now available for most patients, although there are a few sources of honey bee venom. At present, there are many difficulties in "farming" wasps, hornets, and yellow jackets and in efficiently extracting venoms on a commercial scale. Yet this must be the trend for future treatment on a specific basis.¹²

The basic rule to avoid bee stings is: don't look or smell like a flower and avoid places where Hymenoptera are likely to be found! Dress should be neutral or light in color rather than bright or flowery. One should avoid anything that has a strong odor, such as perfumes, hair sprays, or deodorants. Insects may be trapped in loose clothes, so tight fitting garments should be worn. Shoes and socks, along with long pants should be worn to avoid stings on the legs or feet. The patient should avoid areas where there is garbage, flowers, or lawns being mowed. Caution must be used when eating outside because yellow jackets are attracted to food. Painting a house or cleaning walls may cause contact with a wasp's nest. On days when stinging insects are swarming, the patient may wish to stay indoors. A can of quick-acting insect spray should be kept in the car as well as in picnic and eating areas outside. Thiamine chloride (Vitamin B₁) is secreted by the sweat glands and often changes the odor of patients when taken in the dose of 75 to 150 mg. per day. Since the odor of the patient is often what attracts insects, a trial is deserved.¹³

The patient should carry a bee sting kit with him at all times. Hollister-Stier Labs has one available which will deliver two doses of epinephrine at 1 to 1000 dilution, 0.3 ml. in each dose. In addition, there is an antihistamine tablet, an ephedrine-phenobarbital tablet and a

piece of string to be used as a tourniquet. When the patient is stung he should take the antihistamine and tie the tourniquet between the sting and his heart, if the sting occurs on a limb. Ice can be applied to the sting to slow absorption if it is on the head or body. The epinephrine should be used immediately if the patient is having a reaction or if he has had a severe reaction in the past. If no symptoms are felt, it is reasonable for the patient to wait and see before the epinephrine is given if another adult is with him. Examination of the area of the bite should be done. If a stinger is noted to be present, it should be flicked out with a fingernail rather than a tweezer, which would inject more venom into the site.

It is recommended that the patient proceed to the nearest medical facility, if a severe reaction has taken place in the past or if reaction is occurring for the first time. Sublingual isoproterenol has proved ineffective and should not be used.¹⁰ Nebulized epinephrine may be helpful for laryngeal swelling, or for use by people who are not able to inject themselves with epinephrine. Physicians who recommend the use of an antihistamine alone after the sting, and do not provide epinephrine for emergency use, ignore the treatment of choice for anaphylaxis and invite possible lawsuits. Of a recent review of 400 insect-sting deaths, only 6 percent of patients who received epinephrine within one hour of the sting died.¹ (Ninety-seven percent of those who lived after a sting received epinephrine).

The physician who sees a patient with a Hymenoptera sting has many treatment options. If the patient is asymptomatic, he can observe him and do nothing or give him an oral antihistamine tablet, i.e., diphenhydramine HCl 50mg. or chlorpheniramine maleate 4mg. while under observation. If generalized symptoms occur, 0.2 to 0.5 ml of aqueous epinephrine 1 to 1000 should be administered subcutaneously and 50mg diphenhydramine HCl given intravenously. The patient should be observed for symptoms of shock and respiratory difficulties.

If shock occurs, an intravenous infusion should be started and the patient treated with fluids and anti-shock treatment. Antihistamines such as

diphenhydramine HCl 50 to 100mg. plus 100 to 300 mg. of hydrocortisone succinate should be given intravenously. If bronchospasm does not respond to epinephrine, aminophylline, in a dose of 5.6 mg. per kilogram, may be given within 20 to 30 minutes.

Serum sickness reactions which occur ten days to three weeks after the sting may be treated with antihistamines and steroids if necessary. In some cases aspirin may be used for treatment of joint symptoms. An insect sting emergency kit should be obtained by any patient who has had an anaphylactic reaction from an insect sting. The kit should be kept with the patient at all times and ready for instant use. It does no good at home in the refrigerator. In addition a Medic-Alert® bracelet may be worn.†

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Rheumatology — Sheldon Solomon, M.D.

(From "The Cooper Review" published by Cooper Hospital, Camden, where Dr. Solomon is chief attending rheumatologist)

A 27-year old female presented with the complaints of fever, skin rash, and generalized arthralgias. She had recovered recently from an upper respiratory tract infection and had been on penicillin therapy. On physical examination she had a urticaria rash and diffuse adenopathy. Examination of joints revealed some slight tenderness with slight warmth. Blood count revealed Hgb 12.6, WBC 13,600 with 12 percent eosinophils, 62 polys, 26 lymphs. Sed-rate was 32mm/hr.

The most likely diagnosis here is which of the following?

1. Acute rheumatoid arthritis
2. Acute gout
3. Systemic lupus erythematosus
4. Serum sickness reaction to penicillin.

Answer — (4) — The most likely diagnosis would be a serum sickness reaction. This usually occurs in a non-sensitized individual 7 to 12 days following the injection of a foreign substance such as penicillin, and so on. The disease is transient and usually ends within a week to two weeks. Often the only medication needed is an antihistamine or usually low-dose steroids for a short period of time. Although collagen diseases, such as rheumatoid arthritis and lupus can present with such an acute illness, the most practical approach would be to treat the patient as mentioned above and if there is no improvement in one to two weeks, then consider some of the other problems and do appropriate studies.

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Bioequivalence

Form with fields for Name, Address, and Date, and a signature line.

NAME	ADDRESS	DATE
SIGNATURE		



the weight of scientific opinion:

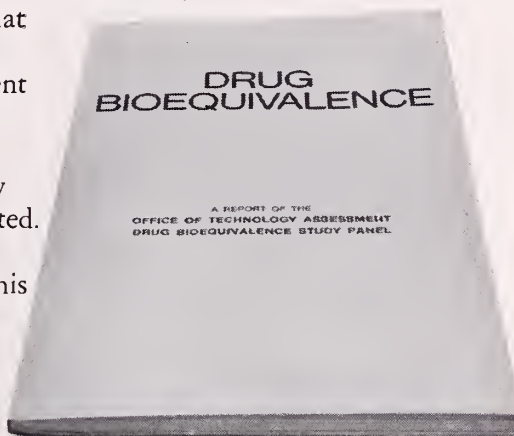
If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalence in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure

that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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Must vasodilators
and therapy for
other diseases
come into
conflict?



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The cerebral or peripheral vascular disease patient often has coexisting disease¹ which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows.

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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In the past, upper gastrointestinal tract hemorrhage has been a diagnostic and therapeutic dilemma. Now, with the use of newer innovations, i.e., panendoscopy and arteriography, specific bleeding can be diagnosed quickly and with excellent accuracy. Duodenoscopy performed as soon as clinically possible has been proved to pinpoint bleeding sites and therapy can be instituted immediately. Barium studies are inaccurate and do not show specific bleeding sites. Studies are now available to show that a team approach comprised of a gastroenterologist, radiologist (arteriographer), and surgeon can accurately diagnose and manage upper gastrointestinal tract hemorrhage.

Aggressive Diagnostic Approach to Upper Gastrointestinal Hemorrhage

Warren Werbitt, M.D./Cherry Hill*

Within the past twenty years, there has been an increased interest in a more vigorous approach to diagnosis in a patient presenting with signs and symptoms of upper gastrointestinal hemorrhage. As the different modes of diagnoses have been refined they have led to a more precise determination and formulation of the diagnosis of the hemorrhage site or sites. Although a complete history and physical examination are still primary, an alert gastrointestinal hemorrhage team (gastroenterologist, radiologist, and surgeon) with modern diagnostic modalities can quickly locate bleeding sites in the upper gastrointestinal tract in most instances. Each specialty within the gastrointestinal hemorrhage team has recently developed modalities so precise that earlier publications, even within the past decade, do not include these modern techniques.¹ With refined duodenoscopic endoscopies, followed by selective and sub-selective arteriography and increased knowledge of techniques of surgery, the treatment of upper gastrointestinal hemorrhage has vastly improved. Within a short period of time after the patient enters an emergency unit a specific diagnosis may be made.² With these modalities, we can improve on previous statistics which showed that 30 percent of patients leaving the hospital with initial upper gastrointestinal tract hemorrhage left without a definitive diagnosis.³

Diagnostic Approach

In reviewing the history, the attending physician must take particular note of the age of the

patient, the previous history of hemorrhage, familial blood dyscrasias, drug or alcohol ingestion, the character and frequency of vomitus, antecedent history of abdominal distress, and the character, amount and frequency of all stools.

During the physical examination the physician should record supine and sitting vital sign determinations, and should look for compromise in the systemic circulation due to hypovolemia, extrahepatic signs of liver disease, and telangiectasia of the mouth and lips. A rectal examination, with notation of the color of the stool, should be done on all patients.

Laboratory Analysis

Initially the patient should have full coagulation studies and hematocrit determinations although the latter respond slowly during active bleeding. Measurement of urinary output and central venous pressure in response to a unit of whole blood may be helpful. Because of hypovolemia, painless myocardial infarction may occur so serial electrocardiograms should be obtained.⁴ Blood for SMA 12/6® should be drawn to uncover diabetes mellitus, renal disease, or liver disease. Adequate quantities of blood should be typed and cross-matched recognizing that patients with liver disease should have at least one fresh unit of whole blood for every four stored units. Serum electrolytes and CO₂ determinations should also be obtained.

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Initial Procedures

The bleeding patient should be placed at bed rest and nasal oxygen administered; intravenous fluids should be started. At this point, for diagnostic purposes, a nasogastric tube should be inserted into the stomach and the aspirate tested for gastric contents and occult blood. The color and character of the material should be noted and the tube then removed. Indwelling nasogastric tubes may irritate cardioesophageal junction lesions or gastritis, although they may be left in place if one is fearful of aspiration. Some institutions⁴ insert a 36 F (or larger) Ewald tube and lavage the stomach with ice water. Others see no advantage to ice water lavage and, in fact, feel this could produce trauma, and induce further bleeding.⁷

Serial measurements of arterial pH and pCO₂ levels should be obtained and sodium bicarbonate administered intravenously to counteract lactacidemia should it appear. The latter results from shock and from metabolism of citrate preservative in blood to lactic acid. Arbitrary supplementation of sodium bicarbonate should not be given, for it may impair transport of oxygen from blood to the tissues and increase metabolic alkalosis.⁶ A central venous pressure catheter should be inserted if bleeding is progressive, for blood volume and adequate hydration must be maintained.

Review of Bleeding Sites

There is no question that the high incidence of hemorrhage from duodenal ulcer as previously taught has now been statistically disproved. In Palmer's⁴ study of 1,400 bleeding patients, duodenal ulcer accounted for only 28 percent, while hemorrhagic gastritis was responsible for 12 percent of patients presenting with gastrointestinal hemorrhage. Morrissey's statistics correspond to this.⁵ In contrast, McCray, *et al.*, reported hemorrhagic gastritis as a cause of gastrointestinal hemorrhage in 46 percent of cases.⁷ Palmer⁸ found esophagitis as a cause of bleeding in 6 percent of all cases and the Mallory-Weiss syndrome in 5 percent. Gastric ulcer was responsible for 13 percent as the site of hemorrhage and anastomotic ulcer 3 percent in Palmer's study. Esophageal varices were found in 19 percent of patients bleeding.⁴

Palmer⁴ noted that one-third of patients with hepatic cirrhosis bled from sites other than varices, while McCray, *et al.*, found only five of twenty-seven patients with known esophageal varices were actually bleeding from varices.⁷ It was also noted that patients with prior gastric surgical procedures were bleeding from sites other than a stomal ulcer in 66 percent of cases.⁴ A prior known upper gastrointestinal lesion doesn't always prove to be the bleeding site and, in fact, in 51 percent of hemorrhage in such patients, different bleeding sites were discovered. Such statistics will undergo even further changes with the advent of the newer duodenoscopes; possibly inflammatory lesions in the duodenal bulb, (erosive duodenitis) may be found to be more prevalent as a site of bleeding. There are discrepancies as to the bleeding sites in patients with upper gastrointestinal tract hemorrhage in various series. This may relate to the locale of the institution where the study was made (rural or urban) or to the endoscopist and his skill. The overall differences are not great, although erosive duodenitis has not yet been shown to be a major cause of upper gastrointestinal tract hemorrhage.³

Endoscopy

Fiberoptic instruments have been so refined that their use is the first diagnostic step in the diagnosis of upper gastrointestinal hemorrhage. Endoscopy which can be completed in five to ten minutes will yield excellent results and should be performed if possible within the first 24 hours,¹⁰ as has been stressed in many reports.¹¹ More than 90 percent of the bleeding lesions can be diagnosed within the first 48 hours.¹² After this period, however, the diagnosis rate falls sharply.

The use of premedication for endoscopy has undergone change with the use of diazepam (Valium[®])¹³ in the actively bleeding patient. Drugs must be titrated according to the clinical situation, with a spectrum from no medication in some patients to that of atropine intramuscularly and diazepam intravenously in others. The dosage of diazepam varies from 2 to 30 mg. with an average dose of 10 mg. intravenously. Meperidine, which is used in elective procedures, is not usually given in emergencies. Larger doses may be required with patients

with alcoholism or patients who have used tranquilizers previously.

Liquid topical anesthetics are applied to the posterior pharynx. As has been suggested by Waye, *et al.*,¹⁴ emptying the stomach in preparing the patient for an emergency endoscopy is unnecessary. The forward viewing duodenoscope is the instrument of choice in viewing upper gastrointestinal bleeding sites including the duodenal bulb, esophagus, and stomach. The side viewing duodenoscope, although excellent for the duodenum will not adequately visualize the entire upper gastrointestinal tract. It has been shown that without visualization of the duodenum, positive diagnoses drop sharply.³

The instrument is passed to the esophagus. The cardio-esophageal junction is viewed, and then the stomach is entered. Diffuse or focal bleeding sites are sought out. If the lesion is not seen, the duodenoscope is passed through the pylorus and the duodenum is viewed. The duodenoscope is passed into the duodenum in over 95 percent of cases and many times into the second portion of the duodenum.

Older reviews have diagnosed bleeding sites in 60 percent of cases.⁴ However, newer studies using panendoscopy have demonstrated bleeding sites in over 90 percent of all cases, often involving multiple sites. With proper control of the instrument in the pharynx, good patient cooperation, and slow advance of the instrument, the risk of perforation is minimized.¹⁵ Perforation occurs in approximately 0.07 percent¹⁶ of all cases. Impaction of the instrument in the esophagus can occur.¹⁷ Intraoperative endoscopy¹⁸ may also be useful to demonstrate a bleeding site.

Arteriography

Percutaneous selective arteriography is another useful method of localizing the site of hemorrhage.¹⁹ In the patient with upper gastrointestinal hemorrhage, the celiac and superior mesenteric arteries may be selectively catheterized. Active bleeding, at a rate of as little as 0.5 cc per minute, can release contrast media into the lumen of the gastrointestinal tract. In the patient with gastrointestinal

hemorrhage which is not well defined with endoscopy, arteriography may provide the answer. In addition, selective mesenteric arterial catheterization with continuous infusion of vasopressin through the catheter can arrest or slow hemorrhage in the upper gastrointestinal tract, including bleeding from esophageal varices.²⁰ It must be stressed that arteriography must precede barium radiographic techniques. Water soluble contrast media give poor x-ray visualization and interfere with arteriography, but will not delay endoscopy.

Arteriography can be used throughout the entire gastrointestinal tract. In the esophagus, localized bleeding tears in the distal esophagus may be observed, as well as lesions at and below the cardio-esophageal junction. Esophageal varices may be demonstrated by selective arteriography, although actual extravastion of contrast media has not been seen. Arteriography, however, does exclude arterial or capillary bleeding, so the patient with esophageal varices and portal hypertension by arteriography without another site of hemorrhage, can be presumed to have variceal hemorrhage. Gastric lesions of various etiologies may be demonstrated readily by arteriography. With proper technique, both benign and malignant gastric ulcers, as well as stress ulcers and drug-induced ulcers, may be seen.

Arteriography will also demonstrate duodenal ulcerations in varied locations. The technique for arteriography may be altered since the celiac artery and superior mesenteric artery both supply the duodenum and both vessels must be demonstrated. Post-bulbar ulcers are particularly well demonstrated by selective arteriography as suggested by Baum²¹ and shown by Conradi.²² Bleeding due to metastatic neoplasms, leiomyomas, and vascular malformations have been demonstrated in the small bowel.^{23, 24}

Patients with portal hypertension and collateral variceal channels but no evidence of arterial bleeding on arteriography may be treated by continuous vasopressin infusion utilizing a Sigmomotor[®] pump at an initial rate of 0.2 pressor units per milliliter per minute.²¹ Vasopressin may be infused continuously while

assessing liver function and suitability for portal-systemic shunt. Because vasopressin decreases arterial blood flow and lowers portal hypertension, intra-arterial vasopressin has been used during elective portosystemic shunt procedures. Results have been excellent with the use of vasopressin for Mallory-Weiss tears, gastric ulcers, and hemorrhagic gastritis. Among the disadvantages are adverse cardiac effects and tachyphylaxis.²⁵ It must be stressed that arteriography with the use of vasopressin, as well as endoscopy, as discussed above, must be performed by qualified, experienced individuals who are aware of the complications.

Barium Radiographic Studies

Conventional barium radiographic techniques fail to demonstrate the source of bleeding in approximately 30 percent of the cases.²⁶ Other studies have shown that barium contrast studies are positive in only approximately 30 percent of the cases.³ At best, the study will demonstrate supportive evidence indirectly, but will not show directly the source of blood loss. The barium meal can establish a lesion, but it cannot tell if it is bleeding. The problems are compounded when more than one lesion is seen on examination — for example, hiatal hernia and duodenal cap deformity. Therefore, the barium meal x-ray examination should be the last radiological procedure performed in the vigorous approach to the patient with upper gastrointestinal hemorrhage.

Surgery

Because of advances in endoscopy and arteriography the surgeon is no longer forced into a "blind" exploratory laparotomy. With the exception of the cirrhotic patient with signs and symptoms of hepatic failure and bleeding esophageal varices, most good risk patients with a well defined lesion do well surgically if the gastrointestinal bleeding doesn't stop spontaneously or with other medical techniques.

With a bleeding duodenal ulcer, there is no universal agreement as to surgical treatment; the age of the patient may play a role: partial gastrectomy with vagotomy may be indicated in a younger patient (under 60), whereas the surgeon may elect a drainage procedure with vagotomy

in an older individual.² These areas remain controversial; debate continues between vagotomy and pyloroplasty and vagotomy and partial gastrectomy.²⁷

Hemorrhagic gastritis has always been a surgical problem. Certainly total gastrectomy would be best, but this is a dangerous procedure. Most surgeons, if forced, perform a gastrectomy and vagotomy in hemorrhagic gastritis.²⁸

Factors that have been reported to predispose to a recurrent hemorrhage, after an initial gastrointestinal "bleed," have been reported to be: (1) a large initial loss of blood, (2) the interval between bleeds (patients who have no evidence of hemorrhage for 48 hours after an initial bleed are less likely to bleed again in the near future), (3) patients with hematemesis have a higher incidence of recurrence of hemorrhage than patients with only melena, (4) etiology of the hemorrhage has a direct bearing on recurrent hemorrhage (esophageal varices have the highest rate of hemorrhage), (5) it is questioned whether the age has any relationship to recurrent hemorrhage.²⁹ Although these points may provide guidelines, statistics vary among different studies and no firm rules on the predictability of gastrointestinal hemorrhage can be made.

Results and Summary

Endoscopy and arteriography have now made early diagnosis of upper gastrointestinal hemorrhage possible. Although the vigorous approach to gastrointestinal hemorrhage is used widely, there have not been any convincing controlled studies to show that it has reduced the morbidity and mortality associated with upper gastrointestinal hemorrhage. Schiller,³⁰ without using frequent endoscopic procedures, had a mortality rate of 8.9 percent in 2,149 cases, as compared to Palmer's⁴ 7.9 percent mortality rate in 1,400 cases using the vigorous endoscopy technique.

These studies did not use the newer modalities, duodenoscopy and arteriography. With the new refined duodenoscopes and the use of arteriography, morbidity and mortality can be sharply reduced. The use of a duodenoscope in

the first 24 hours of an upper gastrointestinal hemorrhage, with or without hematemesis, has shown that we seldom will be faced with a patient without a definitive site of upper gastrointestinal tract hemorrhage.

It is of utmost importance that gastrointestinal hemorrhage teams be organized and coordinated so that necessary data may be obtained. Duodenoscopy and arteriography, if used correctly, largely eliminate the need for upper gastrointestinal tract barium studies which have been shown to be inadequate in the diagnosis of upper gastrointestinal tract hemorrhage.

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The twelve-month post-coronary experience of 58 patients admitted to one hospital with a documented diagnosis of acute myocardial infarction, and under the care of a treating physician and a physicians' assistant (PA) is presented. In the control group (no PA care) the mortality rate was 50 percent; in the study group, it was only 18.2 percent with abnormal risk factors being corrected. This difference was significant at the 95 percent confidence level, but the exact importance of each factor involved in determining ultimate prognosis is still to be determined.

Implementation of Risk Factor Control by Physician's Assistant Following Myocardial Infarction

**A. Stier, R.N., M.S. Gottlieb, M.D.,
A. Fleischman, Ph.D., and
M. Bierenbaum, M.D./Montclair**

In 1965, Duke University established a two-year physicians' assistant (PA) program¹ to train former medical corpsmen and inactive registered nurses. These assistants appeared to increase the physicians' efficiency and to provide the patient with more thorough medical coverage. In 1970, the American Medical Association reported 20 programs for physicians' assistants at 14 locations in 11 states.² These programs provided general, pediatric and orthopedic practices with specially trained assistants. In 1971, the American College of Physicians listed the areas of activities in the subspecialties of internal medicine where the services of physicians' assistants might be of value.³

In view of the ever-increasing awareness of the requirements for adequate medical care, a developmental program for nurse physician assistants was initiated at St. Vincent's Hospital, Montclair, New Jersey. Its purpose was to determine if a physicians' assistant could assist in providing the patient who had suffered a myocardial infarction improved medical care both in the hospital and as an outpatient. This report is a followup on one year of this program.

Materials and Methods

Over a twelve-month period 58 patients, admitted to the program with a documented diagnosis of acute myocardial infarction, were assigned to the physicians' assistant group (A), or control group, (B), and followed for one year.

The patients in both groups had comparable demographic and medical characteristics. There were 33 patients in group (A) and 20 patients in group (B). The PA provided supplemental attention to dietary control for overweight and/or hyperlipidemia, proper adherence to drug regimen, exercise, and smoking advice. Upon admission, the physicians' assistant provided psychological support to both the patient and his family by explaining the pertinent aspects of the patient's history and physical examination and treatment. During the hospital stay, the PA regularly reviewed laboratory test results, medications, and physical signs and symptoms and brought appropriate information to the attention of the attending physician. The risk factors of coronary heart disease and methods of their control were explained to both the patient and family on a continuing basis.

Following discharge from the hospital, the physicians' assistant visited the patient at home on two occasions at approximately weekly intervals. During these and any visits required thereafter, both the patient and the family were counseled on diet, the drug regimen, and exercise rehabilitation. The PA notified the treating physician of all findings so that any indicated changes in treatment might be rapidly instituted by the treating physician. Both the patient and family had access to the physicians' assistant at

*This work is from the Atherosclerosis Research Group at St. Vincent's Hospital in Montclair, where Ms. Stier, Dr. Fleischman, and Dr. Bierenbaum are associated. Dr. Gottlieb is affiliated with Rutgers Medical School, CMDNJ, Piscataway. The research was supported by the Division of Community Health Services, New Jersey State Department of Health, Contract #0-38.

all times so that problems in rehabilitation were more rapidly resolved.

After one year of followup of each subject, the morbidity and mortality data were evaluated. The subjects in the control group were not seen or contacted by the physicians' assistant until the end of the year, at which time the requisite information for statistical analysis was obtained by questionnaire. On average, each subject in the physicians' assistant group (A) was contacted nine times during the year, either by home visits or by telephone. Approximately one third of the contacts were home visits.

Results

No significant difference existed between the two groups in regard to sex, grades of occupation, number of previous infarcts, prodromal days, number of days in the coronary care unit, age at first infarction, or number of weeks from onset of myocardial infarction until the patient returned to work (Table 1). An evaluation of the

Table 1
Comparison of Groups

Number of Patients	A (PA) 33	B (Control) 20	P**
Sex	M 21, F 12	M 14, F 6	N.S.
Occupation			
(Grade 1-4)	11	7	N.S.
(Grade 5-6)	22	13	N.S.
Previous infarcts	1.2 ± 0.1*	1.4 ± 0.2	N.S.
Prodromal days	4.1 ± 0.5	3.4 ± 0.7	N.S.
ECG Q wave	91%	95%	N.S.
No. days in CCU	5.9 ± 0.5	4.8 ± 0.8	N.S.
No. weeks from M1 until return to work	17.2 ± 4.8	17.2 ± 6.9	N.S.
Mean age at first M1	59.9 ± 2.0*	65.1 ± 2.9	N.S.
Mean age at current M1	60.6 ± 2.0	66.5 ± 2.2	0.05
Mean age of patients who died	68.5 ± 4.5	72.4 ± 3.7	N.S.

*Mean ± S.E.M.

**Employing the student "T" test.

mean age at current myocardial infarction indicated that the control group was six years older, ($P < 0.05$). An evaluation of the mean age of patients who died showed no significant difference between the two groups. No significant difference was noted in either the initial mean blood cholesterol or triglycerides between the two groups (Table 2). Twelve percent of the

Table 2
Blood Lipids

	A (PA)	B (Control)	P**
Cholesterol, mg/dL	190 ± 9.3*	183 ± 7.3	N.S.
Triglycerides, mg/dL	181 ± 11	200 ± 32	N.S.
Hyperlipidemic	35%	50%	
Normalipidemic	65%	50%	

*Mean ± S.E.M.

**Employing student "T" test.

treated group and thirty percent of the control group required drug assistance for hypotension, but this was not significant by chi-square tests (Table 3). No significant difference was noted between the two groups in the percentages of patients requiring supportive therapy for congestive heart failure, arrhythmias or hypertension, or treatment with cardiac glycoside or an-

Table 3
Therapeutic Assistance

	A (PA) 33 %	B (Control) 20 %	P*
Hypotension	12	30	N.S.
Congestive heart failure	24	30	N.S.
Arrhythmia requiring drug therapy	45	45	N.S.
Hypertensives receiving treatment	3	5	N.S.
Hypertensives not receiving treatment	15	10	N.S.
Normotensives	79	85	N.S.
Cardiac glycosides	31	45	N.S.
Anticoagulation	41	45	N.S.
Thrombophlebitis present	0	15	N.S.
Weight at discharge:			
Under ideal weight**	9	0	
at ideal weight	36	38	
Over ideal weight	58	63	N.S.

*Employing chi-square test for significance.

**Employing the Metropolitan Life Insurance Co. Table of desired weights by age, sex and body build.

ticoagulants. Fifteen percent of the patients in the control group suffered from thrombophlebitis, while none in the study group were similarly affected. This difference was not significant. At discharge, there was no significant difference in the degree of obesity between

Table 4
Morbidity and Mortality after One Year

	A (PA) 33 %	B (Control) 20 %	P*
Chest pain	52	45	N.S.
Recurrent MI (non fatal)	10	18	N.S.
Hospital for related reason	21	10	N.S.
Returned to work	57	30	N.S.
Weight 1 year later:			
Under ideal weight	7	0	
At ideal weight	44	30	
Overweight	48	70	
Number of survivors	27	10	0.05

*Employing the chi-square test.

the treated and the control group. No significant difference was noted in the number of patients suffering from recurrent myocardial infarction during the year following discharge (Table 4). Approximately twice as many people in the study group returned to work as in the control group.

In the study group there was a 17 percent decrease in the number of overweight individuals with a concomitant increase in the number of subjects at ideal weight after one year. Conversely, in the control group there was an 11 percent increase in the number of overweight individuals. During the year the mortality rate in the control group was 50 percent while in the study group, it was 18.2 percent, an absolute difference of 32 percent in those subjects who died. No significant differences were noted

between these groups in age at death, age at first infarction, percentage of patients with hypertension or thrombophlebitis, or treatment with anticoagulants or cardiac glycosides (Table 5).

Discussion

The one-year mortality rate of 50 percent in the control group was significantly higher and the 18.2 percent in the treated group was significantly lower than the expected rate of 34.1 percent generated from a chi squared test with expected values equal in both groups. Bierenbaum, *et al.*,⁵ reported a four percent expected mortality rate but in a younger age group. Gazes, *et al.*,⁶ noted a one-year mortality rate of 12 percent overall for his patients, but found that those with "S-T" depressions had a one-year mortality rate of 43 percent.

In this study, the groups were not statistically different in the number of previous myocardial infarctions, Q wave changes, arrhythmias, hypertension or the requirement for cardiac glycosides or anticoagulation. Although not statistically significant, the control group was 5.2 years older than the treated group; this could have contributed to the large mortality difference noted between the groups.

In tables 3 and 4, it can be noted that there was a ten percent decrease in the number of overweight patients in the treated group, while there was a seven percent increase in overweight patients in the control group.

From the foregoing data, it seems that the physicians' assistant, by providing educational and psychological support to the patient and his family, may have assisted in the recovery and rehabilitation of the patient who has suffered a myocardial infarction.⁴ The patient and the family were helped to understand the nature of the illness. Included in the process of education were detailed explanations of the various "risk factors," the method of correcting them, and the value to be obtained from such improvements.⁵ Most patients have little idea of the meaning of hyperlipidemia, how to correct marked obesity, what is a proper and adequate exercise program or how one may stop smoking. The physicians' assistant can assist in the resolution of these problems.

Table 5
Comparison of Deceased Subjects in Both Groups

	A (PA)	B (Control)	P**
Total number	33	20	
Number deceased	6	10	0.5
Percent of group	18.2%	50%	0.5
Age at death	68.5 yrs. \pm 4.49*	72.4 \pm 3.74	N.S.
Age at first infarction	68.7 \pm 4.77	71.60 \pm 3.70	N.S.
Hypertensive	10.0%	0%	N.S.
With thrombo- phlebitis	30.0%	0%	N.S.
On anticoagulants	50.0%	33.3%	N.S.
On cardiac glycosides	40.0%	66.7%	N.S.

*Mean \pm S.E.M.

**By Student "T" test and chi-square test as appropriate.

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Assistant to the Primary Care Physician*

The assistant to the primary care physician is a skilled person, qualified by academic and clinical training to provide patient services under the supervision and responsibility of a doctor of medicine or osteopathy who is, in turn, responsible for the performance of that assistant. The assistant may be involved with the patients of the physician in any medical setting for which the physician is responsible.

The function of the assistant to the primary care physician is to perform, under the responsibility and supervision of the physician, diagnostic and therapeutic tasks in order to allow the physician to extend his services through the more effective use of his knowledge, skills, and abilities.

In rendering services to his patients, the primary care physician is traditionally involved in a variety of activities. Some of these activities, including the application of his knowledge toward a logical and systematic evaluation of the patient's problems and planning a program of management and therapy appropriate to the patient, can only be performed by the physician. The assistant to the primary care physician will not supplant the doctor in the sphere of the decision-making required to establish a diagnosis and plan therapy, but will assist in gathering the data necessary to reach decisions and in implementing the therapeutic plan for the patient.

The ultimate role of the assistant to the primary care physician cannot be rigidly defined because of the variations in practice requirements. These

services would include, but need not be limited to, the following:

- 1) The initial approach to a patient of any age group in any setting to elicit a detailed and accurate history, perform an appropriate physical examination, and record and present pertinent data in a manner meaningful to the physician;
- 2) Performance and/or assistance in performance of routine laboratory and related studies as appropriate for a specific practice setting, such as the drawing of blood samples, performance of urinalyses, and the taking of electrocardiographic tracings;
- 3) Performance of such routine procedures as injections, immunizations, and the suturing and care of wounds;
- 4) Instruction and counseling of patients regarding physical and mental health on matters such as diets, disease, therapy, and normal growth and development;
- 5) Assisting the physician in the hospital setting by making patient rounds, recording patient progress notes, accurately and appropriately transcribing and/or executing standing orders and other specific orders at the direction of the supervising physician, and compiling and recording detailed narrative case summaries;
- 6) Providing assistance in the delivery of services to patients requiring continuing care (home, nursing home, extended care facilities, etc.) including the review and monitoring of treatment and therapy plans;
- 7) Independent performance of evaluative and treatment procedures essential to provide an appropriate response to life-threatening emergency situations; and
- 8) Facilitation of the physician's referral of appropriate patients by maintenance of an awareness of the community's various health facilities, agencies, and resources.

*Prepared by the AMA Council on Medical Education in collaboration with the American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Physicians' Assistants, American Society of Internal Medicine, and American College of Physicians.



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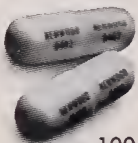
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CASE REPORT

Case report of a 45-year-old male presenting with an asymptomatic swelling of the right submandibular and parotid areas is presented. Sialogram revealed an infiltrating lesion involving the submaxillary and parotid gland which subsequently was proved to represent a lymphoma. The constellation of infiltrating neoplasm with no cranial nerve impairment should suggest the diagnosis of lymphomatous involvement of the salivary gland.

Lymphosarcoma Presenting As Salivary Gland Tumor

**Gordon B. Manashil, M.D. and
S. Thomas Westerman, M.D.
Long Branch***

The purpose of this communication is to report an unusual case of lymphosarcoma presenting in the major salivary glands and to describe the sialographic findings.

Case Report

A 45-year-old male was admitted to Monmouth Medical Center with a ten-week history of swelling of the right parotid region. His past history, family history, and review of systems were essentially normal.

Physical examination revealed a large firm mass over the right parotid submandibular region. Neurologic examination, including cranial nerve examination, was within the limits of normal. The entire physical examination failed to reveal evidence of adenopathy or hepatosplenomegaly.

Routine laboratory results, including blood count, urinalysis and SMA-12 analysis, were all within normal limits. Chest x-ray and intravenous pyelogram were normal.



Figure 1 — Frontal subtraction film illustrating invasive lesion of parotid and submaxillary gland with parenchymal destruction and no sialectasis. Both the parotid and submaxillary glands are filled.



Figure 2 — Lateral roentgenogram at the same time revealing destructive infiltrative lesion.

A sialogram was performed for evaluation of the mass and there was seen to be an invasive lesion involving both the submandibular and parotid region on the right. The parenchyma of both glands revealed extensive destruction and infiltration with no evidence of sialectasis (Figures 1, 2, 3). Preoperative diagnosis on the sialogram was malignant infiltrating neoplasm.

On the fifth hospital day, biopsy of the right parotid gland led to a diagnosis of malignant infiltrating lymphoma, nodular lymphoblastic type. A lymphangiogram, performed one week after the biopsy, revealed extensive involvement of the para-aortic and iliac nodal chains with lymphoma (Figure 4). Bone marrow biopsy was normal. The patient was treated with a course of "total nodal irradiation" for his lymphoma.

Discussion

Tumors of the salivary gland are unusual, accounting for approximately 4 percent of all

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Figure 3 — Close-up frontal film demonstrating destructive mass.

malignancies.^{1, 2} Masses in the salivary gland are divided into an extrinsic and intrinsic group; the intrinsic masses are further subcategorized into encapsulated or invasive lesions. Lymphoma involving the submaxillary or parotid gland is quite unusual. Out of 573 salivary gland tumors listed by Ackerman,¹ lymphoma is listed as rare and no cases are reported. Einstein³ reports six cases in a large series of parotid and submaxillary tumors and there are other scattered reports in the literature.^{1, 4, 5}

Most salivary gland tumors present clinically with swelling and local symptoms. Cranial nerve impairment occurs in approximately one-third of malignant neoplasms of the parotid gland and is the rule unless the lesion arises deep in the gland or in the lower pole of the parotid.¹

This case is important because of the clinical and roentgenographic presentation. Our patient had a painless swelling of the parotid and submandibular gland with no cranial nerve impairment. Sialogram proved to be an extremely useful method of diagnosis in this case, as it revealed an irregular mass lesion with fuzzy ductal outlines



Figure 4 — Film from nodal phase of lymphangiogram illustrating extensive bilateral involvement with lymphoma. Note enlarged foamy nodes.

infiltrating both the parotid and submaxillary glands. The diagnosis of malignant mixed tumor of the parotid or submaxillary gland was not seriously entertained as the lesion is usually well encapsulated and confined to only one gland. More anaplastic lesions, such as epidermoid carcinoma and adenocarcinoma, may be infiltrative but cranial nerve impairment would be expected.

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Each teaspoonful (5 cc) contains:

Elemental Iron (as Ferric Pyrophosphate)	30 mg
L-Lysine HCl	300 mg
Thiamine HCl (B ₁)	10 mg
Pyridoxine HCl (B ₆)	5 mg
Vitamin B ₁₂	25 mcgm
Sorbitol	3.5 Gm
Alcohol	0.75%

DOSAGE: Prevention of iron-deficiency
anemia—Children and Adults—1 tsp. (5 cc)
daily. Treatment of iron-deficiency anemia—
Children: 1 tsp. t.i.d.; Adults: 1 tsp. q.i.d.

SUPPLY: Bottles of 4 fl. oz. and 16 fl. oz.



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compliance problems.

Zip

Breast self-examination:


KEY ROLE OF THE PHYSICIAN

item:	Breast cancer is a major concern of American women, according to a recent Gallup study conducted for the American Cancer Society.
item:	Although aware that early discovery improves the chances of cure, and that BSE can lead to early discovery, <i>fewer than 1 in 5</i> women practice BSE, and <i>only half</i> have an annual breast examination by a physician.
item:	Only 35% of all women polled reported that a <i>physician</i> had ever raised the subject of breast self-examination, and only 24% had received instruction from the physician on how to do it. Even among women who regularly see a gynecologist, only 34% had been instructed on BSE.
item:	<i>But</i> , among women who received personal instruction from their physicians, the overwhelming majority (92%) practiced BSE during the preceding year.

The Gallup study revealed that, far more important than increasing awareness of breast self-examination, is the problem of inducing women to practice it regularly. The physician plays a key role in this—by teaching women the correct technique, and instilling in them the confidence that will assure their continued practice of BSE.

The American Cancer Society gives

major emphasis to breast cancer through research and a vast array of public educational materials, designed to give women life-saving information about the disease. Our latest approach is via a pioneering television film starring Jennifer O'Neill, "Breast Cancer: Where We Are." Where we *will* be in a few years will certainly hinge on our joint efforts.

American Cancer Society 

NEW JERSEY DIVISION
2700 Route 22 PO Box 1220
Union, N.J. 07083

The Health Professions and Child Abuse and Neglect*

A Guide to Fulfilling the Legal Responsibilities of the Medical Profession in Cases of Suspected Child Abuse or Neglect

Abuse and neglect are major causes of physical and emotional damage to children. In New Jersey alone, an estimated 25,000 children suffered and 220 died from abuse or neglect in 1973-74, yet only about one in five cases was reported. Fortunately, community and professional awareness of these serious problems is increasing. (See editorial comment, p. 559 this issue.)

Members of the medical profession often have the first contact with abused and neglected children, whether in private practice, clinics, or hospitals. It is crucially important, therefore, that they remain alert and knowledgeable in dealing with suspected cases. According to New Jersey law, any person having reasonable cause to believe that a child has been subjected to child abuse or neglect must report the situation to the New Jersey Division of Youth and Family Services (DYFS), *even if definite proof is not available*. The law protects the person making the report by guaranteeing immunity from civil or criminal liability resulting from the action. During normal working hours (Mondays through Fridays, 9 a.m. to 5 p.m.) reports should be made by phone to the nearest District Office of the DYFS. (See list at end of this article) At all other times (nights, weekends, and holidays), the DYFS Office of Child Abuse Control maintains a 24-hour, toll-free emergency hotline to receive reports (800-792-8610).

General Procedures

Physicians, hospitals, and clinics receive a wide range of abuse and neglect cases, from the most serious abuse for which a child requires immediate treatment, to problems of poor parenting, which might become apparent during routine examination or treatment for another condition. The DYFS should be informed immediately of all cases, regardless of their severity.

1. *Severe abuse or neglect* occurs when the child has suffered serious injury or injuries inflicted by other than accidental

means, by the person into whose custody the child would be returned. In such cases, the physician should maintain protective custody (described below) and immediately and simultaneously report this action and the case to the DYFS.

2. *Moderate abuse or neglect* occurs when the situation, although not critical, is chronic or continuing, causing actual physical damage to the child: The child lacks a minimal level of food, clothing, shelter, affection, supervision, or medical or dental care; the parents are uncooperative, hostile, and uninterested in help, so that placement or necessary legal action may soon be required. The physician should report such cases immediately to the DYFS.

3. *Problems in child care* are characterized by inadequate parenting or family disorganization. These do not actually constitute abuse or neglect, since minimal standards are met, the home is minimally adequate, and the parents are interested in help. The problem may have appeared recently, and no physical damage has occurred to the child. In these cases, the physician should ask the hospital social work or nursing staff or DYFS to provide counseling and support to the family.

Additional Findings

Certain findings, either individually or in combination, may in some cases indicate abuse or neglect. The physician should use judgment in determining which findings to report.

History — Abused children are frequently brought to the emergency room at night for inappropriate reasons. Histories often reveal previous injuries; previous hospital (especially emergency room) admission for cuts, bruises, burns, poisoning, fractures; and multiple visits to various hospitals.

The Child's Condition — Abused or neglected children show a wide range of reactions. They may be fearful, anxious, tense, or nervous; they may cling to strange adults. Or they may appear apathetic, failing to react even to painful treatments. Often an abused or neglected child is considered "deviant" — hyperactive or a behavior problem. Infants may show "failure to thrive."

*Prepared by the New Jersey Division of Youth and Family Services with the cooperation of the Special Committee on Child Health of The Medical Society of New Jersey and the assistance of Dr. Phoebe Hudson of Hackensack Hospital and Drs. Leta Bagdon, Anna Haroutunian, and Harold Winters of United Hospitals of Newark.

Indications for Reporting Child Abuse

	Under 1 year	1 to 5 years	5 to 12 years
<i>Fracture</i>	<ol style="list-style-type: none"> 1. Any long bone 2. Fractures in different stages of healing 3. Any skull fracture that is not simple linear 4. Epiphyseal separations 5. Metaphyseal lesions 6. Multiple fractures 	<ol style="list-style-type: none"> 1. Multiple fractures 2. Fractures in different stages of healing 3. Any skull fracture not simple linear or explained by trauma 4. Multiple or repeated epiphyseal fractures 	<ol style="list-style-type: none"> 1. Multiple or different stages of healing (to 18 years) 2. Multiple or repeated skull fractures not simple linear or explained by trauma 3. Multiple or repeated epiphyseal fractures (to 18 years)
<i>External Injury</i>	<ol style="list-style-type: none"> 1. Bizarre lesions (reflecting instrument used) 2. Multiple lesions 3. Burns (lye, lye poisoning, cigarette, stocking and glove distribution) 	<ol style="list-style-type: none"> 1. Multiple lesions in unusual locations 2. Bizarre lesions (reflecting instrument used) 3. Repeated burns or poisoning (cigarette, stocking or glove distribution) 	<ol style="list-style-type: none"> 1. Bizarre lesions (reflecting instrument used) (to 18 years) 2. Multiple lesions in unusual locations (to 18 years) 3. Repeated burns or poisoning (cigarette, stocking or glove distribution)
<i>Eyes</i>	<ol style="list-style-type: none"> 1. Retinal detachment without medical cause (to 18 years). 2. Injuries reflecting a direct blow or use of instrument. 		
<i>CNS Injuries</i>	<ol style="list-style-type: none"> 1. Subdural hematoma. (Be suspicious of any head injury. The head is the readiest target). 		
<i>General</i>	<ol style="list-style-type: none"> 1. Severe neglect or malnutrition 2. Significant history (siblings abused, seen in other hospitals). 3. Direct parental threats or admission of abuse or neglect (to 18 years). 4. VD in child 5. Dental injuries 		

The physician should be alert for signs of general neglect and for scars and bruises in locations generally concealed by clothing, such as the neck, back, buttocks, under the arms, behind the knees, and on the tops and bottoms of the feet. Since they often precede a fatal blow, eye injuries are especially significant, and retinal hemorrhages should be noted.

The Parents' Behavior — Parents may reveal their attitude toward their child and whether or not the child's injuries were inflicted accidentally. Parents may delay in seeking medical help, or show reluctance to give information. They may offer an explanation that does not fit the injury, or show an inappropriate reaction to the severity of the injury. In discussing their child, they may have unreasonable expectations for his or her performance or development, or

sometimes claim conditions that do not exist, such as: "She/he bruises easily;" "She/he moves constantly" when the child sits quietly; "She's/he's sickly" when the child seems healthy. Family problems, such as marital discord, crowding, financial stress, psychological disorders, retardation, or alcohol or drug addiction, can affect the parents' potential to abuse or neglect. (Alcoholism is more commonly associated with abuse, drug addiction with neglect.)

Dealing With Parents and Child — The physician should determine if the injured or neglected child has siblings who may also need care. In dealing with the parents, the physician should be sympathetic and reassure them that he or she wishes to help. Often the parents face serious personal problems and it is likely they

themselves were abused as children. A useful phrase might be, "The child's problems seem to warrant more study, and we want to help you."

Neglect — While abuse cases are more likely to show up in the emergency room, neglect can represent an equally grave risk to the child; moreover, the incidence rate may well be higher for neglect than for abuse. Too often, the "battered child" receives medical attention while the neglected child goes unrecognized.

Neglect may take two forms that warrant especially close observation. The first, "failure to thrive" in infants, leads in extreme cases to marasmus and death. The second, prenatal and neonatal neglect, appears commonly among the infants of drug- and alcohol-addicted mothers. These families require special attention and care, including after-care.

In neglect as in abuse cases, early intervention and treatment are crucial. The hospital social service staff, DYFS, or other community social service agencies can and should work with parents whose children show signs of borderline neglect.

The Laws

Two New Jersey statutes directly address the role and responsibilities of the physician in handling and reporting cases of suspected child abuse and neglect. These are:

1. *The Child Abuse and Neglect Law (P.L. 1974 c. 119)*, which became effective January 8, 1975. Under this law:

Physicians, or any other persons, having reason to suspect that a child has been abused or neglected, are required to report directly to the Division of Youth and Family Services and to provide as much pertinent information as possible, including: name and age of the child, address of parent or guardian, description of the child's condition, type of abuse or neglect to which the child has been subjected, an indication of the seriousness of the situation and whether the child appears in immediate or imminent danger, any other information concerning the circumstances of the abuse or neglect, including any evidence of past abuse or maltreatment. *The law also requires that such reports be made only to the DYFS, and not to the County Prosecutor, as required in the past.*

Any writing, record, or photograph done or taken as a regular course of action by any hospital, agency, or institution is admissible as evidence in any court hearing in cases of suspected abuse or neglect. Also, the law requires that any institution, agency, or private practitioner make available to

the Division any past and present records on a particular child — or other children under the care and custody of the same parent or guardian — to aid the agency in its investigation of suspected abuse or neglect.

The privilege of confidential communications between husband-wife, physician-patient, social worker-client is not grounds for excluding any evidence in a court hearing, and the court may require that such evidence be presented.

The court may also authorize a physician or hospital to provide emergency medical or surgical treatment before a complaint on behalf of a child has been filed, if such treatment is necessary to safeguard the child's life or health, and if there is not enough time to file a complaint and conduct a preliminary hearing.

In any case of abuse or neglect, the court may order the examination of a child by a physician, which may include color photographs of visible areas of trauma, as well as radiological examinations. Upon completion of such procedures, the physician is required to submit the results to the court ordering the examination.

Any physician or other person reporting an incident of suspected child abuse or neglect has immunity from any civil or criminal liability. This applies to any testimony given in a judicial proceeding resulting from such action.

2. *The Protective Custody Law (P.L. 1973 c. 147)*, which became effective May 24, 1973. This law, sometimes referred to as the "Hospital Hold" law, empowers any physician or hospital director (or his or her designate) to maintain a child in protective custody without a court order for a period of up to three (3) court days in cases of suspected child abuse or neglect. Under this law:

The physician or hospital representative should notify the Division of Youth and Family Services immediately upon invoking protective custody, and supply the necessary information as outlined in the section on "Physician's Action," which follows.

The District Office of the division then assumes responsibility for: conducting an investigation and, if custody beyond three days is indicated, obtaining a court order and locating suitable placement for the child.

The District Office will inform the parents of the whereabouts of their child, and will then forward a copy of the notification to the hospital or institution where the child is being held, telling how notice was served.

The parents have the right to visit, providing this does not endanger the child. The hospital has the option to determine the time and frequency of visits.

If subsequent investigation indicates further custody is not warranted, the physician or hospital director may terminate custody by contacting the DYFS. The Division may then assume further responsibility and provide additional services, as appropriate.

The person responsible for taking a child into protective custody has immunity from civil or criminal liability.

The Division has available detailed informational packets on each of these laws, copies of which can be obtained by writing to the Division of Youth and Family Services, One South Montgomery Street, Trenton, New Jersey 08625.

The Physician's Action

A physician having reason to suspect abuse or neglect should follow these procedures:

1. Inform the DYFS immediately by phoning the nearest District Office or the toll-free emergency hotline. If advisable, the Protective Custody Law should be invoked at this time.

Provide the following information:

(a) The name of the reporting physician or hospital director or designate, and the phone number at which he or she can be reached.

(b) The child's name, address, and birthdate.

(c) The names and addresses of parents or caretakers.

(d) A description of the child's condition, as detailed as possible, including evidence of previous injuries.

(e) Any further information concerning possible cause or circumstances of the suspected abuse or neglect.

2. Admit the child to the hospital, if indicated.

3. Give a complete physical examination, including:

(a) Radiological tests, as indicated. It is important to remember that, in children, a hairline fracture may not show for two weeks.

(b) CBC, partial thromboplastin, and prothrombin time tests if bruising is present, to rule out a bleeding problem.

(c) An ophthalmological examination if a head injury exists, to reveal possible retinal hemorrhages.

4. Before bandaging, arrange for color photographs of the areas of injury to be taken by the hospital or by the police.

5. Send a complete, written medical report to the appropriate District Office. This should be done as soon as possible after the initial phone report, by either the physician or the hospital director or his/her designate.

6. Report the above actions to the Social Service Department of the hospital as soon as possible.

Social Services Available to the Family

The DYFS will attempt to provide help to the child and his or her family. Services currently available include: day care; homemaker

assistance; family planning; medical care; family, job and personal counseling; periodic home visits; drug and alcohol abuse programs; community mental health centers; and referral to and cooperation with other agencies providing needed services. The DYFS is attempting to establish intensive help, counseling, and treatment programs throughout the State, although many areas now have only basic services. The DYFS seeks a court order to remove a child from his/her home only when absolutely necessary for the child's safety. In most cases, however, effective treatment services can keep a family together and improve its functioning.

Hospital social service departments have a central function in the network of treatment services. They can establish help and treatment programs for families in which abuse or neglect occurs, train hospital staff to recognize and treat cases of abuse or neglect, and help identify potentially abusing or neglecting parents so that they can be offered preventive and rehabilitative services. Hospitals may sponsor additional programs including parent development programs for teenagers and expectant and new parents, classes in functional education (child development, hygiene, nutrition, consumer affairs, and so on), and counseling and referral services when needed. Even after cases are reported to DYFS, the hospital social service staff may continue to play a major part in the treatment program by coordinating medical and social services.

The Division of Youth and Family Services, an arm of the State Department of Institutions and Agencies, urges the cooperation of health care professionals in all cases involving child abuse or neglect. Only when such cases are recognized, reported, and investigated, can intervention be effective. The health care professions play a key role in protecting children and in beginning the process of helping them and their families.

It is neither difficult nor time-consuming to fulfill the responsibility to report. A physician wishing to report a suspected case of child abuse or neglect should phone the nearest DYFS District Office during working hours (9 a.m. to 5 p.m.) or, at all other times, including weekends and holidays, the toll-free, emergency hotline.

District Offices

Atlantic, Cape May Counties
18 S. Arkansas Ave.
Atlantic City 08401
Tel. (609) 344-4141

Bergen County
190 Main St.
Hackensack 07601
(201) 487-5380

Burlington County
50 Rancocas Rd.
Mt. Holly 08060
(609) 267-7550

Camden County
808 Market St.
Camden 08102
(609) 964-4995

Cumberland, Salem Counties
40 E. Broad St.
Bridgeton 08302
Cumberland: (609) 451-3100
Salem: (609) 935-6350

City of Newark
Newark Center Bldg.
1100 Raymond Blvd.
Newark 07102
(201) 648-2644

Suburban Essex County
139 Main St.
Orange 07050
(201) 672-2900

Gloucester County
818 N. Broad St.
Woodbury 08096
(609) 848-6604

Hudson County
910 Bergen Ave.
Jersey City 07306
(201) 653-5750

Hunterdon, Somerset Counties
73 E. High St.
Somerville 08876
(201) 722-2224

Mercer County
1901 N. Olden Ave.
Trenton 08618
(609) 883-7970

Middlesex County
78 Carroll Pl.
New Brunswick 08901
(201) 249-4616

Monmouth County
270 State Hwy. #35
Middletown 07748
(201) 741-5220

Morris County
3 Schuyler Pl.
Morristown 07960
(201) 539-3260

Ocean County
954 Lakewood Rd.
Toms River 08753
(201) 244-4300

Passaic County
370 Broadway
Paterson 07501
(201) 742-1428

Sussex, Warren Counties
200 Woodport Rd.
Sparta 07801
(201) 729-9163

Union County
1155 Magnolia Ave.
Elizabeth 07207
(201) 289-3333

24-hour, toll-free line: 800-792-8610

Suggested Readings

Fontana Vincent: *Somewhere a Child Is Crying*. New York, Macmillan, 1973.

Gil David G: *Violence Against Children*. Cambridge, Massachusetts, Harvard University Press, 1970.

Kempe Henry C and Ray E. Helfer: *The Battered Child*, 2nd ed. Chicago, University of Chicago Press, 1973.

Kempe Henry C and Helfer Ray E: *Helping the Battered Child and His Family*. Lippincott and Co., Philadelphia, 1972.

Young Leontine: *Wednesday's Children: A Study of Child Neglect and Abuse*. New York, McGraw Hill, 1964.

Additional copies of this article in booklet form are available upon request from the Division of Youth and Family Services, one South Montgomery Street, Trenton, New Jersey, 08625. Other publications are available from: The American Humane Association, Children's Division, P.O. Box 1266, Denver, Colorado 80201 and The Child Welfare League of America, 67 Irving Place, New York, New York 10003.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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Ethinyl Estradiol	0.005 mg
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Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

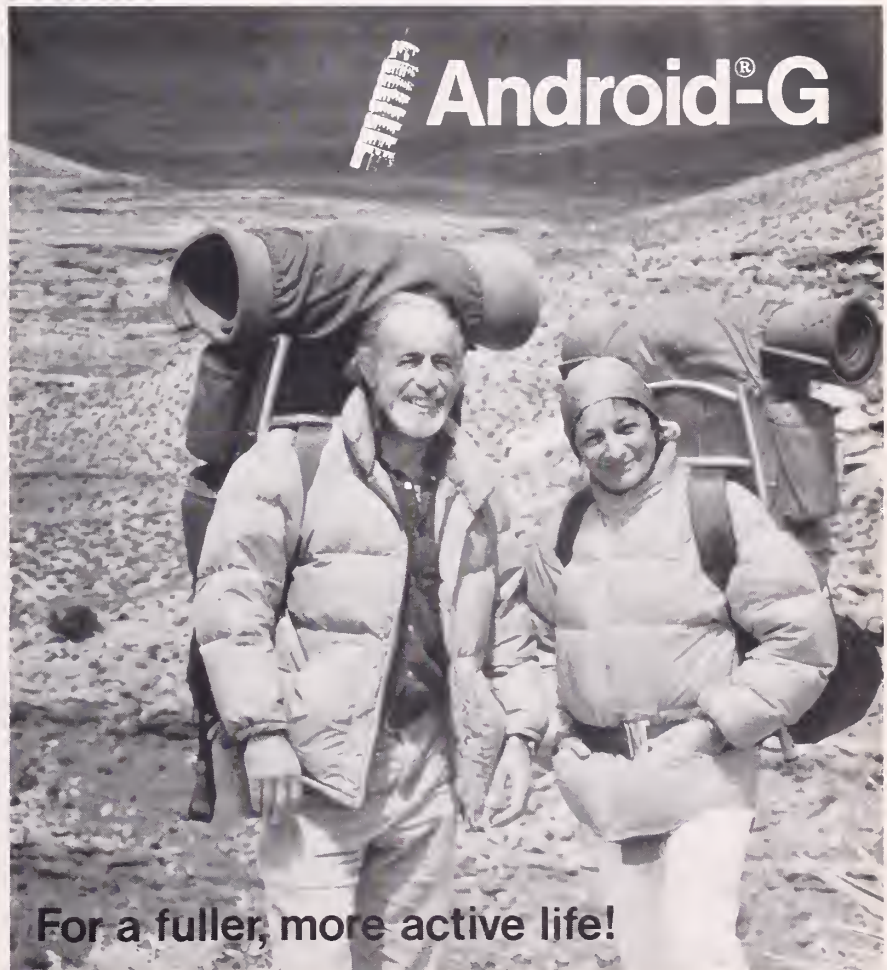
ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period.

PRECAUTIONS: Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

May 18, 1975

A regular meeting of the Board of Trustees was held on May 18, 1975, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Hospital Costs and Rate-Setting Mechanism
... Concurred in the action of the Executive Committee in approving the following policy statement on Hospital Costs and Rate-Setting Mechanism:

The Medical Society of New Jersey is vitally concerned with the current litigation being conducted between some of the hospitals of New Jersey and the Commissioners of Health and Insurance who have chosen to impound 1974 Blue Cross monies due to the hospitals. The real issue, however, is much more extensive than the argument over these monies, since realistically it deals with the Health Care Facilities Planning Act of 1971 and the haphazard, if not often autocratic, way it has been implemented and is being administered in New Jersey.

Our concern is the responsibility that we, the physicians and hospitals of New Jersey, owe to the sick and injured patient. The patient's best interest is paramount and yet under the administration of the law in question it appears to be rarely considered.

Hospitals have been forced to pay increasingly high wages and to recognize unionized bargaining groups. Hospitals are like any other purchaser of goods and services and they must pay the rate that the market has set for the commodity in question.

The provision of high quality health and hospital services requires adequate financing. An artificial rate-setting mechanism which does not evaluate the individual circumstances of hospitals is doomed to catastrophic failure.

The Medical Society of New Jersey, therefore, urges the Commissioners of Health and Insurance to recognize cost increases commensurate with individual hospital evaluation and documentation.

Legislation ... Directed that the following bills, with the positions taken by the Board of Trustees indicated, be referred to the appropriate reference committee:

S-3161 — To amend the definition of podiatry to delete the restriction against major surgery and to embrace the entire foot. *ACTIVE OPPOSITION*, because it would permit podiatrists to perform

procedures and utilize modalities for which they are not adequately trained.

S-3162 — To permit issuance of limited certificates for x-ray technicians in foot radiology. *ACTION DEFERRED*, pending consultation with representatives of the New Jersey Chapter of the American College of Radiology. Final action to be made by the Emergency Action Committee of the Council on Legislation.

S-3163 — To grant immunity from suit to members of peer review committees when acting in good faith in the scope of their function. *APPROVED*

S-3164 — To provide that graduates of accelerated courses in approved colleges of podiatry shall be eligible for licensure in New Jersey. *DISAPPROVED*, because it is evident that accelerated courses have not been as successful as originally planned.

A-3263 — To permit optometrists to advertise and to practice in retail or commercial settings. (Hearing scheduled for May 22, at 10:00 a.m., at Seton Hall University School of Law-Newark.) *ACTIVE OPPOSITION*, since it would commercialize health-care services and increase costs.

A-3273 — To permit advertising of retail prices of prescription drugs and to require pharmacy posting of prices of commonly dispensed prescription drugs. *CONDITIONAL APPROVAL*, providing the portion on advertising is deleted.

... Took the actions indicated on the following bills and referred them to the appropriate reference committees for consideration:

S-130 — Designated the "Local Health Services Act," provides for modern public health services in all municipalities. *ACTION DEFERRED*, pending further information from the Council on Public Health.

S-350 — To require psychological examinations before persons are appointed to a police department. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the psychological examination is conducted under the supervision of a psychiatrist.

S-1077 — To require prescription blanks for prescriptions for controlled dangerous substances to be serially numbered with the name of the prescriber printed immediately preceding the number. *DISAPPROVED*, because this bill, due to a lack of an enforceable system of accountability, would be impossible of implementation.

S-1117 — To delineate the basic rights of persons confined because of mental illness or retardation. *NO ACTION*

- S-1118* — To provide for individual attention to patients confined for mental illness and to establish a judicial review for persons confined beyond 31 days and to provide for legal counsel. *APPROVED*
- S-1119* — To direct the Department of Institutions and Agencies to provide for the establishment of emergency mental health services. *DISAPPROVED*, because the wording of certain sections of this bill will prevent it from achieving the goals which all humane persons deem desirable. It therefore requires further study and amendment.
- S-1127* — To provide for the establishment of medical and dental education programs by the College of Medicine and Dentistry of New Jersey. *APPROVED*
- S-1210* — To provide for licensing of social workers. *DISAPPROVED*, because the bill would permit social workers to use medical modalities and therapeutics when they do not have the training, education, or experience to function in such a capacity.
- S-1214* — To amend and supplement the act providing for registration of physical therapists. *CONDITIONAL APPROVAL*, subject to amendments deleting the use of diagnostic electromyography and inserting the requirement that physical therapy services be rendered at the specific direction or prescription of a plenary licensed physician or surgeon.
- S-1306* — To provide that it shall be unlawful to sell any living or dead human fetus or for any person to purchase, acquire or use such fetus for experimental, research, or transplant purposes. *DISAPPROVED*, because it would make donations pursuant to the Uniform Anatomical Gift Act unlawful.
- S-1407* — To provide for the involuntary commitment of persons believed to be mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-1428* — To regulate long term health care facilities licensed under the Health Care Facilities Planning Act. *NO ACTION*
- S-1483* — To authorize the expenditure of funds for the establishment and maintenance of eye bank facilities and to appropriate \$25,000 for entering into agreements with the New Jersey Eye Bank at the Newark City Hospital. *APPROVED*
- S-1515* — To provide for the examination of pupils and amending New Jersey Statutes 18A:40-4. *APPROVED*
- S-1517* — To require county mental health boards to create the position of mental health administrator. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-1523* — To prohibit the addition of fluorides to any municipal water supply where total fluorides from all sources in the environment exceed an average of 1.2 milligrams per day per person and to require the Department of Environmental Protection to survey all areas of the State for environmental fluoride content. *APPROVED*
- S-1528* — To establish a Drug Utilization Review Council which shall prepare a list of interchangeable drug products and to provide that no drug shall be included in the list until after a public hearing. *ACTIVE OPPOSITION*, because this bill would pre-empt the right of a physician to practice medicine in the manner in which he has been trained and wishes to do for the greatest benefit to the patients' well being and equality. Further, there is no procedure available at this time to guarantee bioavailability or equivalency. There has not been a proper establishment of liability for malpractice in the transfer of responsibility when substituted generic equivalents are implemented. The use of non-professionals on the proposed drug council would jeopardize the selection of proper medication.
- S-1540* — To provide for the establishment of a South Jersey branch of the College of Medicine and Dentistry to be ready to admit candidates for degrees in the Fall of 1976; to appropriate \$50,000. *ACTIVE SUPPORT* Law, c.66 ('75)
- S-3002* — To require every school or commercial bus transporting children to be equipped with seat belts or other restraint systems for each passenger and the driver. *APPROVED*
- S-3017* — To provide that no health care facility shall be operated unless it shall, in the case of skilled and intermediate care nursing facilities, establish and maintain a system of discharge planning which assures every patient a planned program of continuing care which meets his post-discharge needs. *NO ACTION*
- S-3025* — To include residential health care facility under the Health Care Facilities Planning Act and to direct the Commissioner of Health in consultation with the Commissioner of Institutions and Agencies annually to establish a per diem rate of compensation to be paid to public guests of residential health care facilities. *ACTION DEFERRED*, pending a conference with the sponsors.
- S-3035* — To require hospital service corporations to offer home health care coverages. *ACTION DEFERRED*, pending further information from Medical-Surgical Plan of New Jersey.
- S-3040* — To require the use of specified generic drugs in New Jersey's Medicaid Program, to establish a Drug Advisory Council and to appropriate \$50,000. *ACTIVE OPPOSITION*, because this bill would force the use of a substituted generic equivalent drug when there is no procedure available at this time to guarantee bioavailability or equivalency between substituted products. It would discriminate against a segment of the population by possibly legislating inferior medical treatment to that group.

- S-3043* — To provide that no health care facility intended to be used for or in any way applied to the conduct of abortions shall be operated in any municipality unless a referendum on the question is held at a general election. *DISAPPROVED*, because this bill would discriminate against women desiring abortions and would force them to seek services outside of their community. Additionally, the constitutionality of such a statute is suspect in view of U. S. Supreme Court decisions on this topic.
- S-3060* — To provide that no health care facility intended to be operated as an outpatient abortion facility shall receive a certificate of need unless it can be clearly demonstrated that the outpatient facility has a written affiliation with one or more hospitals, that there is a procedure for transmitting pertinent clinical information to the hospital and that there is immediately available transportation. *APPROVED*
- S-3085* — To provide for establishing county boards of health in every county under a "County Environmental Health Act." *APPROVED*
- S-3098* — To provide for the licensing of audiologists and speech pathologists by the Board of Medical Examiners. *DISAPPROVED*, because the bill does not provide that the audiologist is to function at the direction or prescription of a duly licensed physician, a factor which is necessary for sound health care, plus, it is questionable whether licensing would serve any useful purpose.
- S-3122* — To require testing of newborn infants for hearing impairments. *ACTION DEFERRED*, pending further information from the Department of Health.
- S-3128* — To provide for the establishment of a hereditary disorders program. *ACTION DEFERRED*, pending a copy of the bill.
- A-588* — To provide for an examination of members of the police department before appointment thereto by a licensed practicing psychologist or psychiatrist. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the psychological examination is conducted under the supervision of a psychiatrist. Dr. Crosby voted in the negative and asked to be so recorded.
- A-1619* — To provide that any person who knowingly employs an unlicensed x-ray technician shall be guilty of a misdemeanor. *APPROVED*
- A-1583* — To require health care facilities to provide information to persons who need such for obtaining health insurance or receipt of health insurance benefits. *ACTION DEFERRED*, pending a conference with the sponsors of the bill.
- A-1681* — To define conditions under which optometrists shall advise patients to confer with an ophthalmologist. *CONDITIONAL APPROVAL*, provided that suggested amendments are made to the bill.
- A-1690* — To define "Services" in the Retail Installment Sales Act to include work, labor, and services, "professional and otherwise." *NO ACTION*
- A-2086* — To establish qualifications for laboratory directors under the Bio-Analytical Laboratory and Laboratory Directors Act in conformity with the Federal standards for such directors in Title 20, Chapter 3, Part 405 of the code of Federal regulations. *DISAPPROVED*, because this bill would lower the standards of existing statutes and would impose a costly regulation system in lieu of the high quality system already adopted in 44 other states.
- A-2208* — To provide that it shall be a misdemeanor to employ an unlicensed x-ray technician. *APPROVED*
- A-2313* — To permit the Board of Higher Education to award not more than \$6,000 per annum per student to all accredited schools of veterinary medicine which accept New Jersey residents in their degree programs. *APPROVED*
- A-2324* — To require employers to have a first aid kit as prescribed by the Commissioner of Health readily accessible for the treatment of injured persons. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the contents of the kit should be determined by a qualified physician.
- A-2405* — To amend and supplement the act concerning physical therapists defining "physiotherapy," "physical therapist," and "physical therapist assistant," to require a minimum academic standard. *CONDITIONAL APPROVAL*, subject to amendments deleting the use of diagnostic electromyography and inserting the requirement that physical therapy services be rendered at the specific direction or prescription of a plenary licensed physician or surgeon.
- A-3042* — To authorize the Commissioner of Insurance to review and approve the format and provisions of all insurance policies issued by any insurer authorized to do business in this State. *NO ACTION*
- A-3051* — To provide for the licensing and registration of the practice of massage and to create a Board of Massage Examiners. *DISAPPROVED*, because this bill is not of legitimate licensing interest and, further, would authorize chiropractors to prescribe a modality which is outside the scope of their license.
- A-3087* — To establish a program of pharmaceutical assistance to persons 65 years of age and over who earn less than \$6,000 per year. *APPROVED*
- A-3093* — To provide for the Department of Mental Hygiene Act. *DISAPPROVED*, in favor of S-1074.
- A-3094* — To create a New Jersey Medical Malpractice Reinsurance Association, Recovery Fund and Deductible Fund. *ACTIVE OPPOSITION*,

because this bill attempts to apply a theory of casualty insurance to professional liability which is entirely incompatible with logic, reason, and insurance factors. Additionally, there is no "availability" crisis in New Jersey so that the only effect of this bill would be increased cost and destruction of the current market.

A-3109 — To declare it the public policy of the State to encourage the development of community mental health programs in order to minimize the need for admissions and readmissions to State and county hospitals. *APPROVED*

A-3116 — To provide that no health care facility which is intended to be used or applied to the conduct of abortions shall be operated in any municipality unless a referendum on the question is held at a general election. *DISAPPROVED*, because this bill would discriminate against women desiring abortions and would force them to seek services outside of their community. Additionally, the constitutionality of such a statute is suspect in view of U.S. Supreme Court decisions on this topic.

A-3123 — To provide that any employer shall not be liable for continuing treatment under the workmen's compensation law, included but not limited to physical therapy, chiropractic, neurological and neuropsychiatric treatment, unless the employee has obtained a court order for the treatment on formal motion before a judge of compensation, beyond what an employer or carrier will authorize. *DISAPPROVED*, while the principle behind this bill is desirable, the method employed would result in a disservice to the injured and ill worker and would act as a deterrent to prompt diagnosis and treatment. A more favorable approach would be to require the employer to secure an order terminating treatment or declaring further treatment uncompensable.

A-3154 — To provide that no health care facility intended to be operated as an outpatient abortion facility shall receive a certificate of need unless it can be clearly demonstrated that the outpatient facility has a written affiliation with one or more hospitals, that there is a procedure for transmitting pertinent clinical information to the hospital and that there is immediately available transportation. *APPROVED*

A-3214 — To provide for issuance of identification cards and health certificates to minors over age 12 years for use in obtaining employment. *APPROVED*

A-3236 — To require drivers' licenses to contain a space where a sticker will show that he has made a gift of part of his body under the Uniform Anatomical Gifts Act. *APPROVED*

A-3287 — To exempt volunteer, first aid, rescue and ambulance squads from the provisions of the Health Care Facilities Planning Act. *APPROVED*

... Considered the following bills and recommended that they be noted and filed as be-

ing not of intimate concern at this time.

SCR-3001 — To create a special committee to investigate medical malpractice insurance costs and availability and its effect upon the delivery and costs of medical care services.

SCR-3008 — To create a commission to study drug product equivalence and drug product substitution.

SR-3002 — To create a special committee to investigate abortion clinics.

A-3233 — To provide for the Fair Debt Collection Practices Act.

A-3239 — To permit the Commissioner of Institutions and Agencies to designate as a place of confinement any available facility whether owned by a county, municipality or non-profit residential treatment center.

AJR-3003 — To create a commission to determine the number of full time physicians necessary to the efficient functions of the informal hearing process of the Division of Workmen's Compensation.

AJR-3005 — To declare the month of April as Cancer Control Month.

Rules Concerning Sterilization Procedures . . .

Agreed to review the proposed rules concerning sterilization procedures outlined within the physicians, hospital, special hospital, and independent clinic manuals, which, pursuant to NJSA 30:4D-1, et seq., Commissioner Klein has proposed be adopted. If a statement is forthcoming from any Board member, it is to be transmitted in writing to the Executive Director at this administration's final meeting of the Board in Cherry Hill.

Diagnostic Center for Mentally Retarded . . .

Received as informative a communication from Ann Klein, Commissioner of the Department of Institutions and Agencies, indicating pleasure with the action taken by MSNJ's Board of Trustees concerning establishment of a diagnostic center for mentally retarded and other developmentally disabled persons.

Opposition to Utilization Review Position Mandated by DHEW . . .

Directed that a resolution be introduced at MSNJ's House of Delegates similar to that adopted by the Oklahoma State Medical Association in opposition to the utilization review process mandated by Secretary of HEW Weinberger as recorded in the *Federal Register* of November 19, 1974.



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Four tablets (0.5 Gm each) STAT-
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic non-obstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprote thrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. Do you have any information concerning the efficacy of nitroglycerin ointment in the treatment of angina pectoris?

Sublingually administered nitroglycerin provides marked symptomatic benefit in the treatment of angina pectoris due to occlusive coronary disease; however, its brief duration of action limits its usefulness as a prophylactic agent. Cutaneous absorption of nitroglycerin is a well-documented phenomenon which may have unique advantages for the sustained prophylaxis of angina pectoris.

Reichek, *et al.*¹ examined the effect of 2 percent nitroglycerin ointment* and placebo on exercise capacity in 14 patients with angina pectoris. The dose of nitroglycerin ointment, individually selected for each patient, averaged 5 mg. Each

*2 percent nitroglycerin ointment is available as Nitrol, Kremars-Urban; and Nitro-Bid Ointment, Marion

dose of ointment was applied to the same 36 square inch area of the patient's back, covered with plastic wrap and left in place until completion of exercise testing. Nitroglycerin ointment, in contrast to the placebo ointment, produced a significant increase in exercise capacity which persisted for at least three hours. Concomitant sustained changes in systolic blood pressure and resting heart rate were observed. Electrocardiographic evidence of myocardial ischemia was significantly reduced. Chronic administration in six patients did not reduce the effects of either nitroglycerin ointment or sublingual nitroglycerin. The authors conclude that nitroglycerin ointment appears to be a truly long-acting nitrate.

Davis and Wiesel² treated a series of seventeen patients with angina pectoris with a 2 percent nitroglycerin ointment in addition to usual measures. The ointment was applied to the chest wall over an area five to eight inches in diameter. The initial dosage contained 15 mg of nitroglycerin and was applied three or four times daily. Frequency and time of application was governed by the effects on the pain pattern. Nine of these patients showed a decrease in the number of attacks; four patients had no apparent decrease in the number of attacks but had a general feeling of well-being; four patients showed no response. The authors suggested this therapy as an adjuvant in the management of coronary insufficiency.

Attia³ examined the effect of 2 percent nitroglycerin ointment and placebo in fifteen patients with angina pectoris used in conjunction with the usual measures for treatment of patients with severe angina, including sublingual nitroglycerin. None of the patients benefited from the placebo ointment. However, 11 patients showed good improvement when the number of tablets required after using the nitroglycerin ointment was reduced to at least one-half of the number required before its use. The results were considered fair in four patients in whom the number of tablets required was more than half of the original number. The poorest results were obtained in three patients with the diagnosis of sclerotic or calcific aortic stenosis. The author concluded that nitroglycerin ointment was of particular value in patients with nocturnal angina.

In conclusion, the precise place of nitroglycerin ointment within the armamentarium of antianginal agents must be defined by further testing and clinical experience. It appears that in certain patients an application of nitroglycerin ointment in appropriate dosage may produce marked improvement in exercise capacity and in the exercise electrocardiogram for at least three hours.

References

- ¹Reichek N, *et al*: Sustained effects of nitroglycerin ointment in patients with angina pectoris. *Circulation*, 50:348-352, 1974.
- ²Davis J A and Wiesel B H: The treatment of angina pectoris with a nitroglycerin ointment. *Am J Med Sci* 230:259-263, 1955
- ³Attia M.: The treatment of angina pectoris with nitroglycerin ointment. *Cardiol Dig* 7:9-12, 1972.

2. What is the latest recommended treatment for gonorrhea?

The incidence of gonorrhea is increasing sharply, thus it is important to be aware of the latest recommended therapy for this condition. The drug regimen of choice for un-

complicated infections is aqueous procaine penicillin G, (Crysticillin[®], Diurnal Penicillin[®], Duracillin[®], Pentids-P[®], Pfizerpen[®], Wycillin[®]), administered at a dose of 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, together with 1 gm of probenecid (Benemid[®]), by mouth, just before injection. (The long-acting forms of penicillin such as benzathine penicillin G (Bicillin[®], Permapen[®]) have no place in the treatment of gonococcal infections.)

Patients in whom oral therapy is preferred should take ampicillin, 3.5 gm, by mouth, together with 1 gm probenecid by mouth, administered at the same time. Orally administered penicillin preparation, such as penicillin V (Pen-Vee[®], V-cillin[®], Compocillin-VK[®]), are not recommended for the treatment of gonorrhea.

Patients who are allergic to penicillin or probenecid should be treated with tetracycline hydrochloride, 1.5 gm initially by mouth, followed by 0.5 gm given by mouth four times a day for four days or spectinomycin (Trobicin[®]), 2.0 gm administered intramuscularly in one injection.

Physicians are cautioned to use no less than the recommended dosages of antibiotics.

Reference

Henderson R H: Recommended treatment schedules for gonorrhea — 1974. *Arch Intern Med* 135:615-618, 1975.

3. Please provide me with information concerning the use of lactulose in the treatment of hepatic encephalopathy.

Lactulose, a synthetic disaccharide, is used throughout the world for the treatment of hepatic encephalopathy. Although this drug is investigational in the United States, it may be available for emergency use.**

Following administration by the oral route or retention enema, lactulose reaches the colon virtually unchanged where it is broken down by bacteria into organic acids, and acidification of the colon occurs. Although the exact mode of its beneficial action is not known, some investigators believe that the acidic environment produced by lactulose inhibits bacterial production of ammonia, amines, and other potentially comagenic substances.¹ Other investigators believe that the acidity simply traps these formed substances in the intestine.²

James and Garassini³ studied cerebral blood flow and cerebral metabolism in six patients with moderately severe hepatic encephalopathy. The authors concluded that the abnormalities in cerebral metabolism in such patients can be improved by the oral administration of lactulose.

Simmons, *et al.*⁴ in a double blind clinical trial treated 11 patients with hepatic encephalopathy with 80 gm of lactulose daily while ten patients received 60 gm of glucose daily as a control. Encephalopathy and blood ammonia were evaluated during the study. The patients who received lactulose showed

statistically significant reductions in both encephalopathy and blood ammonia levels over the ten-day period as compared to the control patients.

In 1971, Bircher and co-workers⁵ reviewed the literature and found descriptions of 114 patients with chronic portal-systemic encephalopathy treated with lactulose. Overall experience suggested a success rate of 85 percent and indicated lactulose therapy may be particularly useful for long-term control of hepatic encephalopathy. Definitive improvement usually occurred in one to three days, and in chronic cases maximum effect may not be observed until the 10th to 14th day of therapy.

Fessel and Kahn² treated 24 episodes of acute hepatic coma with lactulose and compared the results to 24 retrospectively matched episodes of encephalopathy treated with neomycin. The results of the two treatments were not significantly different.

The side effects associated with lactulose are mild and generally transient. Abdominal distention or cramps and flatulence are reported in the initial stages of treatment, but subside subsequently. The most troublesome side effect of the drug is diarrhea which is usually caused by giving too large a dose. Reduction in dose usually eliminates this. The sweet taste of lactulose syrup is bothersome to some patients; however, this can be masked.

In conclusion, several studies indicate lactulose therapy may be particularly useful in long-term control of hepatic encephalopathy. Patients have shown statistically significant reduction in both encephalopathy and blood ammonia levels. The drug, although investigational, may be available for emergency use.

References

¹Martinetto M and Groth P E: Lactulose. *Hosp Pharm* 10:61-62, 1975.

²Fessel J M and Conn H O: Lactulose in the treatment of acute hepatic encephalopathy. *Am J Med Sci* 266:103-110, 1973.

³James I M and Garassini M: Effect of lactulose on cerebral metabolism in patients with chronic portosystemic encephalopathy. *Gut* 12:702-704, 1971.

⁴Simmons F, *et al*: A controlled clinical trial of lactulose in hepatic encephalopathy. *Gastroenterology* 59:827-832, 1970.

⁵Bircher J, *et al*: Treatment of chronic portal-systemic encephalopathy with lactulose. *Am J Med* 51:148-159, 1971.

**Lactulose may be obtained for emergency use as a 50 percent v/v solution for oral use by contacting the Merrell-National Laboratory, Division of Investigative Gastroenterology, Cincinnati, Ohio — (513) 821-3811

PATRONIZE OUR ADVERTISERS

Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

Criteria

The PSRO law is designed to evaluate the medical necessity, quality, and appropriateness of care rendered to Medicare, Medicaid, and Maternal and Child Health patients. The "S" in PSRO means Standards — Professional Standards Review Organization. The "new" regulations for Medicare and Medicaid have the same aims, and are designed to complement the PSRO function.

Both of these programs require that certain baselines be established to permit evaluation of utilization and the quality and efficiency of the care provided. They both rely on: (1) concurrent review, including admission certification and continued stay review, (2) medical care evaluation studies (MCES), and (3) development of profiles of providers and patients.

"Patterns of care" is a term which has appeared in the last decade. Collections of acceptable patterns of management of various diseases were compiled in Michigan, Minnesota, Pennsylvania, and elsewhere. These have been used in utilization committees and foundations as backgrounds against which actual performance can be compared. These are known variously as books of norms, of standards, and of patterns of care.

Most criteria were developed by a process which NJFHCE followed in preparation of our own set. A committee of the Foundation met and corresponded with representatives of specialty societies in New Jersey, over a long period of time. Each group was asked to prepare sets for the most frequently admitted diagnoses in its specialty. The publication eventually contained 134 diagnoses.

How is our book, or any other, to be used? It is to be regarded as a set of baselines to be adapted locally, to local conditions. The PSRO (under PSRO law) or the hospital utilization committee (under the new regulations) is to use it as a starting point. The experience of the medical staff modifies the criteria in a way that will be useful and meaningful under local conditions.

What are criteria for? I alluded to their purposes earlier. They are guides for comparisons, screening tools, and that's all they are. They permit identification of variations in utilization, in process, outcome, or whatever aspect of care is being examined. They are not the epitome of perfection for each diagnosis. They are not intended to put everyone in the same mold; they do not prohibit innovations; they are not to be used as weapons for any purpose. They do not constitute the frequently-cited "cookbook."

There are two main functions of criteria — in utilization or concurrent review (admission certification and extended, or continued stay review) and also in retrospective review (medical care evaluation studies). In concurrent review usage, the utilization review coordinator should not have to carry a textbook of medicine around with her to see if the committee's guidelines are being met. She needs short, clear, easily understood lists of items permitting quick comparison with the patient's chart. I call your attention to the article in *JAMA*, Volume 232, No. 1, April 7, 1975, entitled: "PSRO — Guidelines for Criteria of Care." Dr. Claude E. Welch, the author, has chaired the task force established by BQA and AMA, with the participation of national specialty societies. The fruits of their labors should be published soon. Dr. Welch lists six elements in *screening* criteria: (1) justification for admission, (2) length of stay, (3) validation of diagnosis and treatment, (4) critical diagnostic and therapeutic services, (5) discharge status, and (6) complications. No more than *five* entries should be listed under each category.

Physicians' Relief Fund

The Physicians' Relief Fund of The Medical Society of New Jersey is available to members of MSNJ in need of financial assistance in time of emergency or catastrophe. Applications are made through your county medical society—write or call the Secretary or the Executive Secretary for information.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY — Purshottam B. Bhangdia, M.D., 9111 Church Ave., Brooklyn, New York 11236. Medical College, Nagpur, India (1962). Group or partnership. Available July 1, 1975.

S. A. Khan, M.D., Room 1018, 5 East 98th Street, New York 10029. Osmania (India) 1966. Board eligible. Group or partnership. Available August 1975.

Tser-Fu Huang, M.D., 32-46 69th Street, Woodside, New York 11377. Kaohsiung (Taiwan) 1969. Board eligible. Group or partnership. Available July, 1975.

CARDIOLOGY — Thomas J. Maley, M.D., 6791 Fisk Ave., San Diego, California 92122. CMDNJ 1970. Board eligible. Any type practice, coronary care and cardiac catheterization desired. Available July 1976.

FAMILY MEDICINE — Robert J. Breiman, M.D., 7801 NE 4th Court, Apt. S14, Miami, Florida 33138. University of Rochester 1973. Board certified. Group or partnership. Available June 1976.

INTERNAL MEDICINE — Pravinbhai C. Patel, M.D., 254-22 74th Ave., Glen Oaks, New York 11004. Baroda Medical College (India). Board certified. Subspecialty, pulmonary medicine. Group, partnership, solo. Available July 1975.

Shyam S. Tangri, M.D., P.O. Box 1749, Butler, Pa. 16001. Medical College, Amritsar, India 1961. Subspecialty, chest diseases. Board eligible. Group, partnership, institution. Available.

Fred H. Hyer, M.D., 6640 SW 5th Street, Hollywood, Florida 33023. CMDNJ 1970. Board eligible. Group or solo. Available August 1975.

Haresh Kantilal Ajmera, M.D., 82 Amity Street, Brooklyn, New York 11201. Bombay University 1969. Subspecialty, gastroenterology. Board certified. Any type practice. Available July 1975.

NEUROLOGY — Muhammad Aslam, M.D., Mayfair Apts., A-2, May Drive, Schuylkill Haven, Pennsylvania 17972. Nishtar (Pakistan) 1967. Board eligible. Solo or associate. Available June 1975.

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Criteria Changes in Category I, AMA Accreditation Review Process

The Academy of Medicine of New Jersey calls to the attention of the directors and coordinators of continuing medical education programs in hospitals, societies, and agencies the following criteria changes in the CME review process for granting Category I, AMA Accreditation, effective immediately, which were adopted on recommendation of its Committee on Education.

1. Submit review requests *90 days* in advance of the meeting date.
2. Submit curriculum vitae or other documentation of a speaker's expertise on his subject area. The Academy's scientific sections will continue to provide a preliminary review of symposia and speakers in their specialty. Where no Academy scientific section exists (i.e., gastroenterology) panels will be formed from the Fellowship.
3. Clearly define the objective(s) of the overall program in addition to listing the topic to be discussed. The AMA defines a Category I program as one that is planned, coordinated, administered, and evaluated in terms of specific educational objectives for a defined group of physicians (or physician).
4. To ascertain on-the-spot evaluation, impartial professional reviewers will be asked periodically to sit in on Academy-sponsored meetings. The reviewer would report to the Education Committee any findings contrary to the material submitted by the applicant which formed the basis for the original approval. Program sponsors will be informed of the presence of reviewers when possible.

These changes have resulted from discussions with the AMA and the newly-formed National Coordinating Council on Medical Education. Tightened control on quality assurance criteria for CME accreditation will be in effect; requests will be examined in terms of the AMA definition of Category I, as noted above in item #3.

LETTERS TO THE JOURNAL

On with "On"

May 15, 1975

Dear Doctor Krosnick:

I enjoyed your "On" editorial very much (*JMSNJ* 72:377 (May) 1975). I think that few people realize that the only true happiness in life is being an "on" person. I think not only physicians but all society have failed to realize this and there are too many of us in a constant "off" position.

I also support your concluding statement about getting back to the basics and I firmly believe that the Ten Commandments are worth a try because aside from everything else, they are damn good health rules.

Many thanks for a good editorial.

(signed) Joseph P. Donnelly, M.D.

May 27, 1975

Dear Dr. Krosnick:

RE: "ON" (*JMSNJ* 72:377 (May) 1975)

I enjoyed your editorial on the above-captioned word with all of its varifications. It is a philosophy that I have always believed and practiced. Thanks for putting it down in words.

(signed) Max M. Novich, M.D.

Dr. Krosnick Named to National Commission on Diabetes

Our Editor, Arthur Krosnick, M.D., has been appointed a consultant to the Subcommittee on Education and Treatment of the National Commission on Diabetes. The National Commission is composed of seventeen members: seven are the Directors of the National Institutes of Health,

six are scientists or physicians, and four are from the general public. It is charged with the responsibility of making recommendations to the Congress for a national program of research, patient, public, and professional education, early detection, and proper control of diabetes.

CLINICAL NOTES

False Aneurysm of the Profundus Femoral Artery Following Nail-Plate Fixation for Intertrochanteric Fracture of the Hip*

Ching-Jen Wang, M.D./Trenton

False aneurysm of the profundus femoral artery is a rare but serious complication following fracture or surgery of the hip. It can be caused by fracture fragment, drill point, depth gauge and surgery of the hip. Approximately one percent of the false aneurysms occur after surgical procedures. Atheromatous aneurysms of the peripheral arteries are uncommon and usually involve the popliteal artery and the iliofemoral junctions.

The following case history will illustrate false aneurysm.

A 72-year-old male was admitted to the hospital on May 8, 1974, because of a comminuted and displaced intertrochanteric fracture of the right hip as the result of a fall. (Figure 1) No other significant injuries were noted at that time.

Past history revealed no history of intermittent claudication, vertigo, or headache.

On May 14, 1974, after a complete medical evaluation, surgery was performed and the fracture was treated by open reduction and nail-plate fixation (Figure 2). The postoperative course was uneventful and the patient was released from the hospital to a local rehabilitation center eight days later.

The patient was next seen on June 24, 1974, at which time he complained of progressively painful swelling on his right groin and upper thigh; there was no history of a second fall. Examination revealed a tense, swollen, indurated and tender right groin and upper thigh. The range of motion of the right hip was restricted because of pain. The right femoral pulsation was difficult to palpate because of the swelling. The left femoral

and both popliteal and dorsalis pedis pulsations were satisfactory. Arteriosclerotic bruits were audible on both groin regions. Roentgenographic examination of the right hip showed the fracture was well stabilized by the nail-plate.



Figure 1 — Showing comminuted intertrochanteric fracture of the right hip.

A tentative diagnosis of aneurysm of the right femoral artery prompted immediate hospitalization. A vascular surgeon performed an arteriogram which showed active bleeding from the profundus femoral artery approximately 2.5" below the bifurcation (Figure 3). Emergency surgical exploratory operation was performed and an active bleeder from a ruptured false aneurysm of the profundus femoral artery was discovered and controlled by direct closure. Post-operatively, the patient did well and was discharged on July 5, 1974.

*This report is from the Trenton Orthopaedic Group, 735 Hamilton Avenue, Trenton, New Jersey 08629.



Figure 2 — Showing the nail-plate fixation for the fractured right hip.

The patient was last examined on April 18, 1975; the fracture was completely healed. He walks

with a slight limp but had no pain. The range of motion of the right hip was satisfactory, and peripheral circulation of both legs was good.



Figure 3 — Arteriogram of the right femoral artery demonstrates an active bleeding from the profundus femoral artery.

References

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3. Fordyce A: False aneurysm of the profunda femoris artery following nail-plate fixation of an intertrochanteric fracture. *J Bone & Joint Surg* 50:141, 1968

Early Diagnosis of Latent Phlebitis

Josef Bergmeyer, M.D./Newfoundland

In the earliest days of my practice, I had the good fortune to be befriended by an extraordinary man, Doctor Otto Meyer, a 1921 graduate of the University of Rostock, Germany, who maintained an office in New York City until his untimely death in an automobile accident in 1950. Dr. Meyer published many articles on phlebitis and rheumatism, in which he described examination for the earliest possible findings of phlebitis occulta.

The following description is a translation in abstract form from one of the many articles written by Dr. Meyer to describe the technique

used by him to discover the earliest manifestations of latent phlebitis in the lower extremities.

"Latent phlebitis is an inflammation of the veins. It can be acute or chronic. The characteristic is that it is always latent or occult, so that the objective and subjective symptoms are extraordinarily minor in nature. In by far the greater number of cases, it is found in the deep veins of the lower extremities. Because of the hidden nature of the morbidity, the patient is frequently not aware of the fact that the seat of his disease is in the lower extremities, and his complaints, therefore, do not give the physician a direct indication of the cause of his difficulties. This morbidity is not only frequent, but it is also important as the cause of a number of other diseases, especially those rheumatic in character which can only be eliminated by removal of the latent phlebitis.

"The symptoms of latent phlebitis are usually minimal. Subjectively, there are complaints of heaviness of the legs, and complaints on climbing stairs. Standing gives more com-

plaints than walking. Leg cramps at night are frequent. The first steps on arising are often accompanied by pain which disappears partly or totally on walking. The fact that the complaints are more pronounced on standing than on walking is very important in the differential diagnosis. In certain arterial diseases of the legs, the opposite is the case. General symptoms of general tiredness are almost always present, even with the slightest exertion. Objective symptoms are scant. The skin may have an oily, shiny appearance. Eczema of the lower leg with severe pruritus is a sign of existing phlebitis of the deep veins which must, however, be differentiated from eczema of varicose veins. Edema is usually not present. When present, it develops during the day and disappears almost completely at night. The patient then complains that his legs swell at night.

"A cardinal symptom is pain which increases or, if the symptoms are minimal, may be found by pressure on the inflamed tissue."

Meyer found a sensitivity to pressure over the deep veins of the lower leg, in every case of latent phlebitis. He found and described three pressure points in the lower leg where one can almost always produce pain in this condition.

"These pressure points are all located medially to the tibia. To find them, one presses with the flat palmar surface of the thumb: (1) in the lower one-third of the lower leg, the posterior tibial vein from the posterior side against the medial edge of the tibia; (2) in the middle one-third of the leg, the pressure point is immediately alongside the tibia; and (3) in

the upper one-third of the leg, it is about two fingerbreadths away from the tibia, all on the medial side. This pressure pain points definitely to the existence of a phlebitis. If this proper examination does not show any pain, one can exclude with almost absolute certainty that a phlebitis is present."¹

Other pressure points shown to me by Dr. Meyer are: (1) over the veins; under the instep of the foot (lift the leg and press with the flat part of the thumb against the veins under the instep of the foot on the medial side while holding the foot with the fingers on the dorsum of the foot) and (2) in the mid-thigh, again on the medial side (exert pressure with the flat of the thumb against the vessels and the femur). It takes some experience in order to interpret the amount of tenderness found.

It would be an excellent idea for pathologists to examine the veins of the legs, especially in cases of proved early and latent phlebitis at post-mortem examination, and to include histological and bacteriological studies.

Reference

¹Meyer Otto: Early diagnosis of latent phlebitis. *Deutsche Medizinische Wochenschrift* 15:595, 1935

Commentary

Professional Liability

New Jersey physicians have been in a relatively comfortable professional liability position, compared to their counterparts in New York, California, and elsewhere, but the peace is an uneasy one for most and a "bed-of-nails" for orthopedic surgeons and neurosurgeons, in particular. As everyone may know, Chubb and Son, the parent company of Federal Insurance Company, has insured more than two-thirds of the state's physicians since 1971. With the withdrawal of Argonaut and Liberty Mutual (who recently dropped the American College of Physicians) and limited offerings by others, more physicians have become interested in the Medical Society program. Premiums here (as elsewhere) have increased: 10 percent in 1971, 35 percent in 1973, a variable increase in 1974 (5 to 10 percent in low-risk categories, 80 percent for

orthopedic surgeons, and 200 percent for neurosurgeons) and a 48 percent increase has been requested for the policy year beginning November 1, 1975. It is believed that premium increases are based on higher awards rather than an increase in the number of suits.

We are all inundated by discussions in newspapers and magazines, our scientific publications, and specialty journals on the subject of the medical "malpractice mess," its causes and hypothetical cures. There has been much smoke and heat generated, but little light on the subject, while extreme polarization of the medical profession, legal profession, insurance industry, state and local governments, and the patient population and consumer advocates has occurred. In a word, the problem is complex, but all such issues are. Does complex mean insoluble? Do solutions need to be immediate and total, or can they be short-term and temporary,

while long-term programs are worked out? One can answer best by a pragmatic, unemotional look at the anatomy and pathology of the issues. Some of these seem quite clear:

1. Patients deserve protection from malpractice.
2. The medical profession requires protection from unjustified suit or threat of suit.
3. The medical profession needs protection from exorbitant professional liability insurance premiums.
4. The insurance industry requires protection from unreasonable settlements and awards.
5. The public must be protected from higher medical costs as a direct and indirect result of the malpractice problem.
6. Malpractice attorneys are entitled to adequate compensation for their work.

In evaluating the issues, one can conclude that there are a number of interlocking "needs:"

1. We need a clear definition of informed consent.
2. We need an explicit definition of malpractice.
3. There must be a reduction in the statutes of limitation to reasonable time frames.
4. There must be a limitation placed on the amount of awards.
5. There must be further modification of the "sliding scale" for contingency fees, or it must be eliminated for some other system of fee-payment for legal services.
6. Medical care providers need a clear and concise definition of the circumstances under which they may file a counter claim.

Anecdotal data, accusations, and counter-accusations are not productive. A California malpractice attorney, defending the contingency fee as "the poor man's ticket to the courthouse," declared "the vast majority of people cannot afford to pay for a skilled, talented, hard-working lawyer on an hourly basis." How many poor or not-so-poor people can afford to pay (out-of-pocket) for a skilled, talented, hard-working cardiovascular surgeon, orthopedic surgeon, or neurosurgeon who performs respectively a triple coronary bypass operation, a total hip replacement, or a resection of a brain tumor? This is precisely the kind of statement which makes the medical profession (most of whom are skilled, talented, and hard-working) "square-off" against the legal profession (most of whom are also skilled, talented, and hard-working) to the

detriment of all. The few incompetent physicians who are responsible for gross malpractice and gross negligence play into the hands of some patients and some plaintiffs' attorneys who are waiting and looking for just such opportunities. Meanwhile, the vast majority of honest physicians, lawyers, insurers, and government officials are caught in this quagmire which threatens to bankrupt hospitals, reduce the availability of skilled physicians' services and further injure the essential mutual trust of the traditional physician-patient relationship.

So — what is to be done?

1. Abandon the tort system?
2. Adopt a workmen's compensation-like system?
3. Establish State Medical Injury Liability Commissions?
4. Develop screening panels of physicians, lawyers, and laymen?
5. Pass legislation which would ensure the availability of professional liability insurance for doctors and hospitals?
6. Eliminate the collateral-source rule and require full disclosure?

All of these will take time and a considerable amount of "give-and-take" on the part of the special interest groups. It is unfair to criticize the medical profession "for failure to police itself" as the major cause for the present dilemma. No profession has done as much to enhance each practitioner's skills and knowledge as the medical profession. From medical school to post-graduate education, from hospital credential requirements to peer review system, from state licensure to specialty examination certification, re-examination, and re-certification, our profession is "light-years" ahead of the legal profession, government officials, and the insurance industry.

Each special interest group must "police" itself and seek appropriate and just solutions or everyone will suffer. Meanwhile, as Dr. Malcolm Todd, President of the American Medical Association, told us at our recent annual meeting, we must go forward on a long and short term solution to the professional liability problem and "must work more aggressively to remove the 'bad apples' through peer review activity."

A.K.

ANNOUNCEMENTS

Retraining Program for Inactive Physicians

The Medical College of Pennsylvania is accepting applications for the Fall 1975 and Spring 1976 retraining programs for inactive physicians. Deadline for the Fall applications is September 1st, and for Spring, March 1st. Each session is eight weeks and provides clinical training for those who wish to re-enter practice by offering review of physical diagnostic skills, experience in clinical rotations, and lecture series on general medicine, pathophysiology, diagnosis, and patient management. For application and additional information, please write to Retraining Program, Center for Women in Medicine, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129.

Diagnostic Ultrasound in Obstetrics and Gynecology

On September 11 and 12, 1975, a comprehensive course on the value of diagnostic ultrasound as applied to obstetrics and gynecology will be offered by the Johns Hopkins Hospital in Baltimore. The faculty has been selected for its outstanding contribution to the field of gynecological ultrasound. Fourteen hours of AMA Category I accreditation is available. For additional information, please write to Ms. D. Magner, Department of Radiology, The Johns Hopkins Hospital, Baltimore 21205.

CME Programs at Bridgeton Hospital

The Bridgeton Hospital announces the following continuing medical education courses to be held at the hospital at 6:30 p.m. on the Wednesdays and Thursdays indicated:

Sept. 11	Endoscopy and Acute Problems in Gastroenterology
Sept. 24	Congestive Heart Failure and Hypertension
Oct. 9	Acute and Chronic Brain Disease
Oct. 29	Acute Psychiatric Problems
Nov. 13	Techniques and Capabilities of Radiology Diagnosis
Nov. 26	Pelvic Disease — Office Gynecology
Dec. 11	Venereal Diseases

For additional information, please communicate with Sherman Garrison, M.D., Director of Medical Education, The Bridgeton Hospital, Bridgeton 08302.

Symposium on Medicolegal Crisis

On October 1, 1975, the Carrier Clinic Foundation will hold its 15th annual symposium at the Clinic's facility in Belle Mead. Entitled "The Medicolegal Crisis: A Psychosocial Evolution," the program runs from 1 to 4:30 p.m. and will be chaired by A. Arthur Sugerman, M.D., Director of Research at the Foundation. The faculty includes Walter H. Beckman, Jr., J.D., Professor of Law at University of Miami Law School; Robert S. Garber, M.D., President of Carrier Clinic; William F. Martin, J.D., a practicing attorney from New York; David S. Rubsamen, M.D., L.L.B., liaison physician to the California Bar Association; and Jonas R. Rappeport, M.D., Associate Professor of Psychiatry, School of Medicine, and Adjunct Professor, School of Law, University of Maryland. A panel discussion with audience participation will close the session. Registration is required. For information please communicate with A. A. Sugerman, M.D., Director of Research, Carrier Clinic Foundation, Belle Mead 08502.

Survey of Gynecology and Obstetrics

From October 6 through 10, 1975, the St. Barnabas Medical Center in Livingston will offer a graduate course for obstetricians and gynecologists on the clinical correlations of various histopathologic entities of the female genital tract as encountered in their specialties. Gross and microscopic material will be studied and related to the clinical picture of various diseases, including diagnosis and therapy.

The course is approved for 40 credit hours in category I of the AMA Physician's Recognition Award. Enrollment is limited and is on a first-come basis. Tuition is \$375 and covers the cost of instruction, booklets, and 100 selected slides

with descriptions. A \$25 deposit is required at the time of registration; the balance is payable on or before October 1st. A limited number of accommodations have been set aside at two nearby motels. For information, please communicate with James L. Breen, M.D., Research Fund, Department of Obstetrics and Gynecology, St. Barnabas Medical Center, Livingston, New Jersey 07039.

Clinical Immunology and Allergy Courses

From October 15 to 19, 1975, the American Association for Clinical Immunology and Allergy will convene in Palm Springs, Califor-

nia. An outstanding faculty has been engaged for a series of presentations on each of three days, with the opportunity offered for "examinations" every morning and every noon; the last morning will be devoted entirely to free discussion of questions previously submitted to the faculty by those attending the sessions. Sports activities have been arranged for the day preceding the beginning of the scientific programs and social affairs are planned for each evening. Additional events have been arranged for those who accompany the attendees. The tuition is \$75 for members; \$115 for non-members; \$10 for residents. Please direct inquiries to Mr. Howard Silber, AACIA, P.O. Box 912, Omaha, Nebraska 68101.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

July

11 Family Practice Seminars

18 1 hour each — Overlook Hospital, Summit

25 *(Sponsored by Overlook Hospital and AAFP)*

16 Hypertension

1 p.m. — Trenton Psychiatric Hospital

(Sponsored by NJRMP, Nephrology Society of New Jersey and Academy of Medicine)

18 Hypertension

12 noon — Freehold Area Hospital, Freehold

(Sponsored by NJRMP, Nephrology Society of New Jersey and Academy of Medicine)

22 Sigmoidoscopy

29 1 hour each — Overlook Hospital, Summit

(Sponsored by Overlook Hospital and AAFP)

Aug.

1 Dermatological Manifestations of Internal Disease

12 noon — St. Mary's Hospital, Orange

(Sponsored by St. Mary's Hospital and Academy of Medicine)

1 Family Practice Seminars

8 1 hour each — Overlook Hospital, Summit

15 *(Sponsored by Overlook Hospital and AAFP)*

22

29

5 Psychiatric Case Conferences

7:30 p.m. — Trenton Psychiatric Hospital, Trenton

(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)

Sept.

2 Psychiatric Case Conferences

7:30 p.m. — Trenton Psychiatric Hospital, Trenton

(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)

11 Colloquium on Primary Care

Downtown Motel, Newark

(Sponsored by New Jersey Medical School and NJAFP)

11 Endoscopy and Acute Problems in Gastroenterology

6:30 p.m. — Bridgeton Hospital, Bridgeton

(Sponsored by Bridgeton Hospital)

24 Congestive Heart Failure and Hypertension

6:30 p.m. — Bridgeton Hospital, Bridgeton

(Sponsored by Bridgeton Hospital)

30 Management of Difficult Psychiatric Patient

2 p.m. — Trenton Psychiatric Hospital, Trenton

(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)

Oct.

1 Symposium: Medicolegal Crises — A Psychosocial Evolution

1-4 p.m. — Carrier Clinic, Belle Mead

(Sponsored by Carrier Clinic Foundation)

2-4 Trauma

Martland Hospital, Newark

(Sponsored by Martland Hospital and the New Jersey Academy of Family Physicians)

18 Respiratory Therapy Symposium

8:30 a.m.-1:00 p.m. — St. Barnabas Hospital,

Livingston

(Sponsored by St. Barnabas Hospital and New Jersey State Society of Anesthesiologists)

29 Diagnosis of Pelvic Disease

6:30 p.m. — Bridgeton Hospital, Bridgeton

(Sponsored by Bridgeton Hospital)

Nov.

13 Radiology Diagnosis

6:30 p.m. — Bridgeton Hospital, Bridgeton

(Sponsored by Bridgeton Hospital)

OBITUARIES

Dr. Bernard A. Balsis

One of Mercer County's well-known ophthalmologists, Bernard A. Balsis, M.D., died suddenly on June 6, 1975, in Cleveland, Ohio, where he was attending an ophthalmic microsurgery course at Case Western Reserve University School of Medicine. Born in 1911 and a graduate of Hahnemann Medical College in 1937, Dr. Balsis was board certified in ophthalmology and was on the senior attending staff in that department at Helene Fuld Medical Center in Trenton. He also held staff appointments at Wills Eye Hospital in Philadelphia and at Lower Bucks Hospital in Bristol. He was a member of the American Academy of Ophthalmology and Otolaryngology, the American Association of Ophthalmology, the New Jersey Academy of Ophthalmology and Otolaryngology, and the International Eye Foundation. During World War II, Dr. Balsis served in the medical department of the Army in the Pacific-Asiatic theater.

Dr. Robert Barnett

Robert W. Barnett, M.D., a cardiologist whose offices were located in Asbury Park, died on May 29, 1975, at Monmouth Medical Center in Long Branch where he had long been a member of the active staff. A graduate of New York Medical College in 1940, Dr. Barnett pursued residencies in internal medicine and cardiology at Columbia Presbyterian and Mt. Sinai Hospitals in New York. He was board-certified in his chosen fields and was a Fellow of the American College of Physicians and of the

American College of Chest Physicians. His professional memberships included the American and New Jersey Societies of Internal Medicine, the Pan-American Society of Medicine, and the New York Cardiological Society. Dr. Barnett was 59 years old at the time of his death.

Dr. Robert Berman

Word has been received of the death, on May 10, 1975, of Robert Berman, M.D., a member of our Essex County component. Dr. Berman practiced obstetrics and gynecology in Newark and South Orange for 50 years before retirement to Fort Lauderdale, Florida, where he died after a long illness. Born in 1900, he received his bachelor's degree from Yale University and his M.D. from Columbia University's College of Physicians and Surgeons in 1925. He initiated the use of x-ray for detection of breast cancer over 20 years ago and was a lecturer and author of a textbook on the use of x-ray in obstetrics. He taught obstetrics and gynecology at New York University Medical School and was on the attending staffs at Margaret Hague Medical Center in Jersey City, Newark Beth Israel Medical Center, Martland Hospital Unit, CMDNJ, and St. Barnabas Medical Center in Livingston, where he helped to establish the use of ultrasound in the diagnosis of breast disease. Dr. Berman was a Fellow of the American College of Surgeons, a Diplomate of the American Board of Obstetrics and Gynecology, and a Founding Fellow of the American College of Obstetricians and Gynecologists.

Dr. John J. Laurusonis

John J. Laurusonis, M.D., a member of our Gloucester County component, died on May 9, 1975. A native of New Jersey, Dr. Laurusonis was graduated from Temple University Medical School in 1940 and following internship served for four and a half years in the medical department of the U.S. Army. He then located in the Gibbstown area where he practiced general medicine until the present. He was a Past-President of the Gloucester County Medical Society and had staff appointments at West Jersey Hospital in Camden, Underwood Memorial Hospital in Woodbury, and the West Park Hospital in Philadelphia. He was a member of the American Academy of Family Practice. He was interested in industrial medicine and was staff physician at the Hercules Corporation in Gibbstown and Monsanto Corporation in Bridgeport. Dr. Laurusonis' activities outside the profession included membership in the Franklin Institute, the Academy of Natural Sciences, and the Philadelphia Museum of Art. Dr. Laurusonis was 60 years old at the time of his death.

Dr. Milton Lilien

One of Union County's senior practitioners, Milton Lilien, M.D., of Hillside, died on May 10, 1975, at St. Barnabas Medical Center in Livingston, where he had been chief of the department of general practice. Born in New York City, Dr. Lilien received his bachelor's degree from Johns Hopkins University and his medical degree from Long Island University in 1929, and practiced general medicine and surgery in Hillside for many years. In addition to his appointment at St. Barnabas, Dr. Lilien was associated with the Beth Israel Medical Center in Newark. Interested in civic affairs, he was a Past-President of his local Kiwanis Club and active in the Italian-American Civic Little League. He was 73 years old at the time of his death.

Dr. John F. Regan

A member of our Union County component, John F. Regan, M.D., who practiced psychiatry in Elizabeth, Short Hills, and more recently in Milford, died on May 9, 1975. Born in 1914, Dr. Regan was graduated from Seton Hall University in 1936, and earned his medical degree from Georgetown University in 1955. Following in-

ternship at St. Michael's Hospital in Newark, he took a three-year residency in neuropsychiatry at the Veterans Hospital in Lyons. He was associated with St. Michael's Hospital in Newark, the Roosevelt Hospital in Metuchen, the Rahway Hospital, and the Union County Psychiatric Clinic. During World War II, Dr. Regan served with the Army in the Pacific theater for four years.

Dr. John G. Walker, Jr.

On May 8, 1975, John C. Walker, M.D., the chief of plastic surgery and rehabilitation at St. Barnabas Medical Center, died at that institution. Born in 1916 in Mississippi, Dr. Walker was graduated from Tulane University Medical School in 1942 and served for three years with the medical department of the U.S. Army. He came to New Jersey for a residency in plastic surgery in 1947 and began the practice of that specialty in Glen Ridge in 1950; subsequently he located in East Orange and Livingston. At St. Barnabas he was secretary of the medical staff and of the executive committee of the medical board; he was chairman of the credentials committee and a member of the committee on graduate medical education. He also had staff appointments at Babies Hospital and St. Michael's Hospital in Newark. Dr. Walker was board certified in plastic surgery, a Fellow of the American College of Surgeons, a member of the American Association of Plastic Surgeons, the American Society of Plastic and Reconstructive Surgery, the American Cleft Palate Society, the American Burn Society, and a founding member of the New Jersey Society of Plastic Surgeons.

Dr. Solomon B. Zinkin

A member of our Ocean County Medical Society, Solomon B. Zinkin, M.D., died on May 21, 1975, in Lakewood, where he had practiced general medicine and surgery all of his professional career. Born in 1915 and graduated from the University of Maryland Medical School, class of 1940, Dr. Zinkin completed his surgical residency at the Bronx Hospital in New York. He was a member of the surgical staff at the Paul Kimball Hospital in Lakewood. He was active also in local affairs and was on the Lakewood Board of Health and was township police physician and physician for the Lakewood public schools.

BOOK REVIEWS

Diagnosis and Treatment of Thyroid Diseases. Kenneth Sterling. Cleveland, CRC Press, 1975. Pp. 113. (\$39.95)

Following his own research interests, Dr. Sterling utilizes a good portion of this book, intended as an introduction to the diagnosis and treatment of thyroid diseases, in developing very thoroughly and lucidly the topics of iodine and thyroid hormone metabolism and of thyroid function tests.

In addition to covering the categories of hyperthyroidism, hypothyroidism, non-toxic goiter, thyroid carcinoma, and thyroiditis, this book also presents interesting short discussions on mechanisms of hormone action and on some theoretical problems concerning the pathogenesis of Grave's Disease, including the possible role of emotional factors.

Dr. Sterling states that "... thyrotoxicosis (hyperthyroidism) is probably more prevalent than all the other endocrine diseases combined, with the exception of diabetes mellitus." This undoubtedly reflects the experience at the Thyroid Clinic at the Columbia-Presbyterian Medical Center, but it is contrary to my personal experience in a general internal medicine practice in which hypothyroidism presented itself frequently and hyperthyroidism quite rarely.

Hyman W. Fisher, M.D.

Developments in Lymphoid Cell Biology. A. Arthur Gottlieb, M.D., Cleveland, Ohio, CRC Press, 1974, Pp. 176 (\$35).

This hard cover, attractively and firmly bound book of 176 pages contains an almost incredible amount of current knowledge about modern theories of the immune mechanism, both as to its good and bad effects on the animal organism. Actually the reading matter is only 133 pages, there being 36 pages of references and a 6-page complete index.

The text is comprised of a short introduction written by Dr. Gottlieb, and then seven chapters entitled as follows: 1. Interactions between Lymphoid Cells; 2. Role of Macrophages in the Immune Response; 3. Eosinophiles in Humoral and Cell-Mediated Responses; 4. The Immunobiology of Tolerance to a Bacterial Antigen: Cellular and Molecular Aspects; 5. Molecular Analysis of Lymphocyte Transformation; 6. Transplantation: Immunogenetics and Effector Mechanisms; 7. The Lung as an Organ of the Lymphoid System. In Chapter I, Dr. Gottlieb highlights areas of lymphoid cell biology to facilitate understanding of the next six chapters. These latter chapters, each being authored by one or more persons from prestigious institutions in the eastern United States, deeply explore the problem named.

The principal problem in life (or to use contemporary jargon "the name of the game") is survival. This book tells almost the complete story of the basic biologic requirements for

defense against (and usually survival) the many substances which are foreign to one's own body components. Our knowledge of the immune response as now understood and clearly explained in this book is complex and rapidly advancing. I believe that within two to three years a book such as this will serve only as a primer. Hence, I strongly recommend this as required reading for all physicians who wish to understand "self and non-self" — and after all that is all of us. Read it and watch your "T" cells and then I know you will become fascinated by all the complex interactions of the human immune mechanism. This is must reading for all internists, pathologists, dermatologists and allergists.

Hugh F. Luddecke, M.D.

Interpretation of Schizophrenia. Second Edition, Revised. Silvano Arieti, M.D. New York, Basic Books, 1974. Pp. 756. (\$19.85)

This monumental work must be brought to the attention of the medical world not only for its classic descriptive and voluminous scientific content but as a piece of fascinating literature. Dr. Arieti carries the story of this tragic area of the human scene from Kraepelinian Dementia Praecox, conceived in categorical genius and damned with prognostic nihilism in the atmosphere of the stifling insane asylums of the nineteenth century through Bleuler's dynamic revisional conception subsumed by his opus, *The Schizophrenias*, in which Bleuler felt out the autistic drives and their relationship to thought disorders and the usage by schizophrenics of Freudian symbolism to Arieti's *Principle of Progressive Teleologic Regression*.

Between the big words Dr. Arieti uses a fluent and simple language. He tells of his discovering, as every psychiatrist who leaves the psychiatric institution discovers, that prognosis in most schizophrenics is apt to be as good if not better than the prognosis for recovery to health in most of the neurotics who are treated outside of institutional settings. This prognosis, of course, depends upon the therapist's ability to relate with understanding and not with fear and rejection. Dr. Arieti understands schizophrenic thinking. His understanding is predicated to a large degree upon his great classical educational background which includes a working familiarity with philosophy, logic, anthropology, and linguistics. It makes one wonder whether more medical students should not be drawn from the humanities than the empirical sciences.

Part three of this book, "The World of Schizophrenia: A Psychostructural Approach," is a trip through a Disney-world of strange but familiar language, of loneliness that every one can share, of weird art that we do not believe awake but remember from our dreams, of emotional experiences that we hear from delirium, all treated with scientific precision.

Dr. Arieti is at home with the chemical and physical adjuncts to therapy and at peace with the limits of his understanding. This book is not a system but a road to travel to greater horizons. He has a kind word for everyone with great tribute to Von Domarus and a gentle attitude to Thomas Szasz. The reviewer is impelled to add that without Freud there would have been no contribution by Bleuler nor even this present work by Arieti, for the unconscious discovered by Freud surfaces in schizophrenia.

Ira S. Ross, M.D.

Medical Malpractice Law. Angelo Roddey Holder, J.D. New York, Wiley, 1975. Pp. 561. (\$22.50)

Angela Roddey Holder's legal analyses have been read primarily within the pages of *Prism* and the *Journal of the American Medical Association*. Her recent publication, *Medical Malpractice Law*, is further evidence of her ability to deal competently with the complex subject of legal medicine.

Mrs. Holder presents such topics as the creation of the physician-patient relationship, duty of due-care, misdiagnosis, incorrect or inadequate treatment, injuries from therapeutic agents, consent to treatment, and many more. This brief listing sounds reminiscent of the many patient allegations of malpractice with which today's physician must contend.

Medical Malpractice Law is a singularly impressive textbook by virtue of the overwhelming number of legal cases which are cited. In excess of 1,000 actual case citations are used by the author to exemplify the points she wishes to make for her readers. These cases are an invaluable reference source for anybody wishing to pursue in further detail the medical and legal points raised.

The cases presented in the text deal with every specialty area of medicine. Since law evolves in great part on the basis of cases which have already been decided, it would seem beneficial for the physician to be aware of those types of cases which have resulted in lawsuits in the past. By such awareness the physician might better be able to make legally safe his own situation when confronting similar facts or circumstances.

Medical Malpractice Law is a recommended text for all practitioners. By reading this text the practitioner can deal more knowledgeably with the plague of medical malpractice.

James E. George, M.D., J.D.

Microanalysis in Medical Biochemistry, 5th edition. I. D. P. Wootton. London and Edinburgh, Churchill Livingstone, 1974. Pp. 307 (\$15.50)

The fifth edition of this volume is a landmark in the chemical laboratory field. Here one may review the tedious and exhausting procedures the biochemist had to perform in order to carry his workload in the laboratory and contrast the same with the automated techniques now in vogue. Thus one is enabled to appreciate how the modern laboratory has attained the ability to produce tests in large volume and of varied types.

Comments pertaining to the pathologic physiology and differential diagnosis of the material under discussion head many of the chapters and sections of the book. While several of the reported techniques of analysis could be labeled "antique," nevertheless they are historical.

Our only criticism is that in this country the dose of *glucose* or *dextrose* administered to adults for the routine glucose tolerance test is 100 gms., not 50 gms. as recorded in the volume.

Those who are interested in medical biochemistry will find the book useful. It should be available to students of medical technology and even medical practitioners could enhance

their understanding of technical reactions by perusing its pages. They might even learn not to request Bence-Jones protein determinations on a urine which gives a negative reaction for protein, or they could learn that dysprosium, gadolinium, holmium, lanthanum, praseodymium and ytterbium are still in the atomic table of the elements.

Thomas K. Rathmell, M.D.

Sociological Aspects of Drug Dependence. Charles Winick, Ph.D. Cleveland, Ohio, CRC Press, 1974. Pp. 327. (\$39.95)

This book is a splendid collection of authoritative and comprehensive papers by persons prominent in the behavioral sciences. Topics have been grouped into sections on theory; education and mass communications; some dimensions of users and prevalence; treatment and re-socialization of the drug dependent; and social costs.

Each paper is very comprehensive and goes into detail in a lucid fashion. For example, Dr. George Nash, who is Director of Drug Abuse Treatment Information Project at Montclair State College, in a paper on the sociology of Phoenix House, gives an excellent portrayal of Phoenix House, ranging from its historical background to a description of actual physical plant. This sort of paper can be invaluable for a physician who is working with patients or families of patients who may need to be involved in this sort of program.

The titles of the papers are varied and include such topics as psychotropic drug use in American families; drug dependence among nurses; and the drug abuse-crime syndrome.

The book contains information that is necessary for a physician to have in order to empathize with those suffering from drug dependence. It is handsomely bound and printed, however, I fear its price will discourage many from purchasing it.

Seymour F. Kuvin, M.D.

Current Surgical Diagnosis and Treatment. J. E. Dunphy and L. W. Woy. Los Altos, California, Lange, 1975. Pp. 1123. Illustrated. (\$15 — softback)

In this second edition, Dunphy and Way have continued their aim to produce a compact and precise surgical reference for the student, resident, and practitioner of surgery. Indeed, as a reference all physicians will find this volume useful. The chapters are concise, well organized, and all-inclusive with current reference appended to each section allowing for more in-depth study as needed. Although rather sparse, the illustrations and tables are clear and relevant.

As a starting point for surgical conventional wisdom in compendium form, this work achieves its purpose. However, by trying to satisfy all levels of surgical need, of necessity there is over-simplification which the sophisticated surgeon will find dull. The practicing surgeon will find the volume useful primarily for review; medical students and interns will find the greatest use for this book, and it can be heartily recommended to them as a spring board for a dive of whatsoever depth they may desire into current surgical diagnosis and treatment.

James S. Todd, M.D.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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- b. Issue date: 10th of month.
- c. Mailing date: 10th of month

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c. Number of issues sent after subscription expiration: None.

5. Special Issues: Convention (April); Annual Transactions (July or August); Index (December)

6. **Editorial Content:** Original scientific articles, special articles, case reports, editorials, medical news and meeting notices, trustees' minutes, communicable disease reports, state legislation, convention, medical insurance, PSRO, education, etc.

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14. Circulation:

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15. Guaranteed Circulation:

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17. Rates Per Thousand:

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THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1975

18. Coverage and Market

a. Coverage: All members of The Medical Society of New Jersey, plus trade circulation of approximately 650 medical libraries, drug manufacturers, medical book publishers, medical abstract services, advertisers, advertising agencies, subscriptions. Circulation figures as of 6-1-75.

b. GP	2,875
IM	1,642
GS	1,263
OBG	712
PED	595
DERM	171
ALL	73
UROL	189
EMT	378
PSYCH	558
OPH	333
RETIRED	225
TOTAL	9,014

c. Trade Circulation:

Non-member physicians	
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Drug manufacturers	
Medical book publishers	
Medical abstract services	
Advertisers	
Advertising agencies	
Subscriptions	
Total approximately	650

19. MEMBERSHIP CIRCULATION BY COUNTIES OF STATE OF NEW JERSEY

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Bergen	1
Burlington	
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Gloucester	
Hudson	
Hunterdon	
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Sussex	
Union	
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Guaranteed Circulation: 9,500

THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1975

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- Issue Date: 10th of month
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2. Agency Commission: 15%

3. Cash Discount: 2%, 10 days.

4. Rates:

	1 time	3 times	6 times	12 times
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1 page	235	220	205	190
1/2 page	130	120	110	100
1/4 page	65	60	55	50
1/8 page	45	40	35	30

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- b. List of standard colors: AAAA standard red, green, blue, yellow, orange.
- c. Matched Colors: \$115 plus earned black and white rate.
- d. 3-color rate: \$315, plus earned black and white rate
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THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1975

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THE JOURNAL is printed by offset.

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31. Plate Sizes:

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1 full page	7 x 10
½ horizontal	7 x 4⅞
½ vertical	3⅜ x 10
¼ horizontal	7 x 2⅜
¼ vertical	3⅜ x 4⅞
⅛ horizontal	7 x 1⅞
⅛ vertical	3⅜ x 2⅜

32. Bleed Size

Page Unit	Dimensions
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Untrimmed size — 8¼ x 11¼

34. Paper Stock: Covers: 80-pound.

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36. Halftone Screen: Up to 133 screen

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38. Closing Dates:

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39. Disposition of Reproduction Material:

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Meeting Place: Auditorium, Middlesex General Hospital, 180 Somerset Street, New Brunswick, New Jersey.

Dates: Wednesdays, 9 to 11 a.m., starting September 24, 1975 and ending May 26, 1976.

Beginning this September and ending the last Wednesday in May, 1976, the Postgraduate Course, "Recent Advances in Internal Medicine and Therapeutics," will be given as in previous years at Middlesex General Hospital in New Brunswick. The Course is sponsored by the New Jersey State and Middlesex County Chapters of the American Academy of Family Physicians, The Academy of Medicine of New Jersey, and Middlesex General Hospital, New Brunswick.

The Course provides university credit toward meeting the requirement of the AAFP (totalling 68 points for the 34 sessions) and the Continuing Education requirement of the Medical Society of New Jersey (68 hours).

As in previous years, the 20th year of the Course is designed to provide clear and concise reviews of important advances in internal medicine which are of practical interest to internists and primary physicians in family practice. All 34 of the two-hour Wednesday morning sessions are conducted by outstanding physicians of the medical faculties of New York, Boston, Philadelphia and other metropolitan centers. During the sessions opportunity is given to discuss with the speakers aspects of clinical problems which arise in the care of individual patients. The 1975-1976 Course will be devoted to discussions of infection and immunity, neuropsychiatric problems, genetics, disorders of the liver, heart and lungs, dietary problems, breast disorders, kidney disease, intestinal disease, allergy, dermatology, the use of antibiotics, etc. The opening session is set for Wednesday, September 24, 1975.

IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM, IT IS IMPORTANT THAT YOU WRITE IMMEDIATELY TO THE CHAIRMAN OF THE COURSE, DR. S. E. MOOLTEN, MIDDLESEX GENERAL HOSPITAL, NEW BRUNSWICK, NEW JERSEY.

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precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction.

tion; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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AUGUST 1975
VOL. 72, NO. 8

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BRIEF SUMMARY

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CONTRAINDICATION: Known hypersensitivity to glutethimide.

WARNINGS: Caution patients (1) about possible combined effects with alcohol and other CNS depressants; (2) operating machinery, driving motor vehicles or engaging in activities requiring complete alertness shortly after ingesting drug. Dosage of coumarin anticoagulants may require adjustments during and on cessation of glutethimide.

Physical and Psychological Dependence: Physical and psychological dependence have occurred. Prescribe cautiously for patients known to take excessive quantities of drugs. Limit repeated prescriptions without adequate medical supervision. Withdrawal symptoms include nausea, abdominal discomfort, tremors, convulsions, and delirium. Newborn infants of mothers dependent on glutethimide may also exhibit withdrawal symptoms. In the presence of dependence, dosage should be reduced gradually.

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PRECAUTIONS: Total daily dosage above 1 Gm. is not recommended for continued administration. In presence of pain, which may counteract the effect of glutethimide, an analgesic should also be prescribed.

ADVERSE REACTIONS: Withdraw glutethimide if a generalized skin rash occurs. Rash usually clears spontaneously within a few days after withdrawal. Occasionally, a purpuric or urticarial rash may occur; exfoliative dermatitis has been reported rarely. With recommended doses, there have been rare reports of nausea, hangover, paradoxical excitation, and blurring of vision. Rarely, acute hypersensitivity reactions, porphyria, and blood dyscrasias (thrombocytopenic purpura, aplastic anemia, leukopenia) have been reported.

DOSAGE: To avoid overdosage, individualize dosage. Not recommended for children under 12.

To induce sleep:

In insomnia: 0.25 to 0.5 Gm. at bedtime. Repeat dose if necessary, but not less than 4 hours before arising.

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Claims processing and payment has been assigned number one priority—therefore, we have had to cut back on areas normally termed “service.”

You have been most understanding. And we want you to know that we appreciate your cooperation.

As we write this, (some six weeks before the date you will read it, because of advertising deadlines) we have no way of knowing what the situation will be when you read your Medical Journal in mid-August. Either the strike will be settled—or it will still be in existence. Of one thing we are quite sure, however—your claims will have been paid in a normal, or even faster than normal manner. And we’re proud of being able to do the job.

We have witnessed a signal phenomenon—and we want to share it with you. You might call it esprit de corps, or perhaps a spirit of camaraderie. But whatever you call it, it adds up to something very special. It adds up to a group of people working effectively together under the dual pressures of long working days and unfamiliar tasks.

People who a month ago didn’t know a “data sheet” from an “EOMB” are concentrating on putting it all together. People who seldom have worked a machine have become instant key-punch operators. People to whom routine, repetitive tasks were something done by someone else have worked on such assignments from early morn to early eve.

Older employees and summer-employed college students have worked side-by-side sharing the tensions of unaccustomed jobs. Officers have been out on the floors working in the midst of young people on their first jobs.

These have been difficult but rewarding times. Times when we’ve all been working together for our subscribers and for you.

Sincerely,

Joseph P. Donnelly, M.D.
President

Working Together To Serve You During The Strike

[illegible]

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of New Jersey

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August 1975

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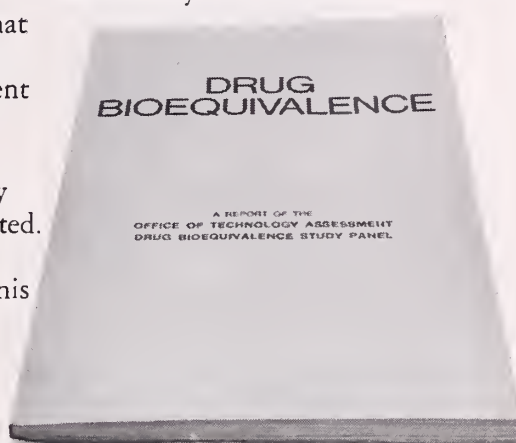
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Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure

that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

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(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

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*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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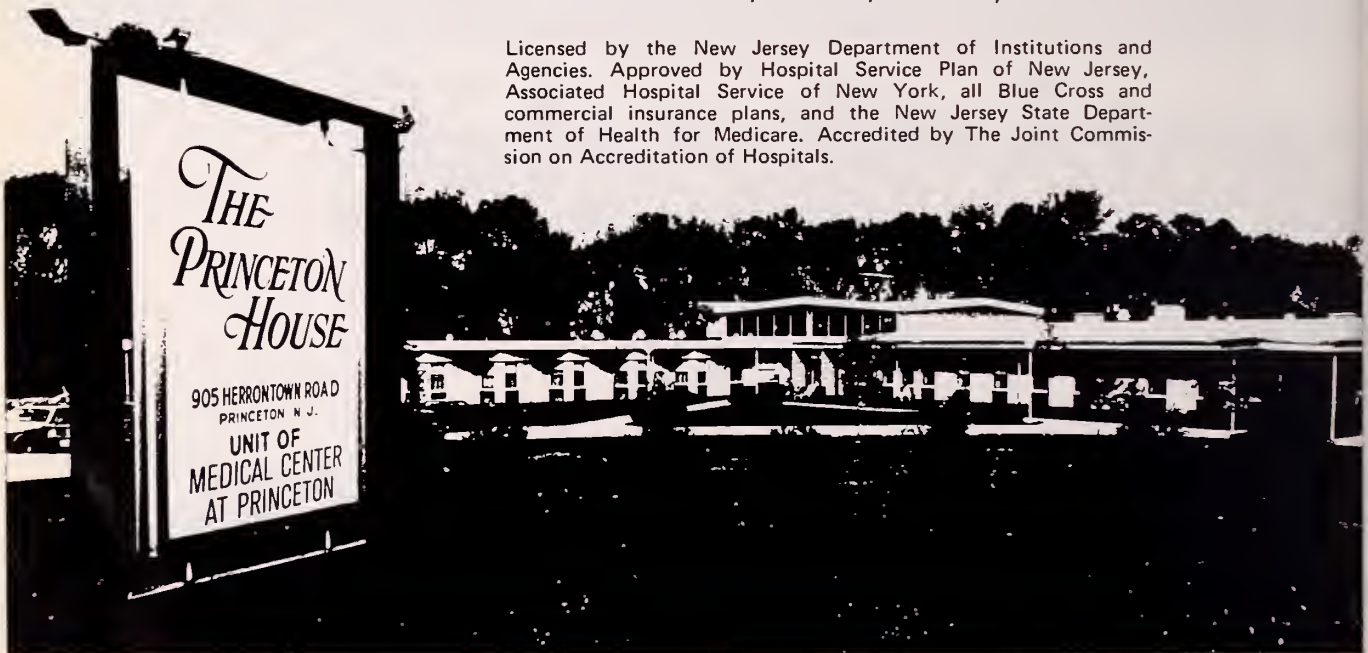
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We know you will agree that this action is in the best interest of your patients. If you have any questions about the name change, contact us directly at (201) 235-2357, or through your Roche representative. Before prescribing LAROTID, please consult the complete product information, a summary of which appears at the right.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Infections due to susceptible strains of the following gram-negative organisms: *H. influenzae*, *E. coli*, *P. mirabilis* and *N. gonorrhoeae*; and gram-positive organisms: streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Therapy may be instituted prior to obtaining results from bacteriological and susceptibility studies to determine causative organisms and susceptibility to amoxicillin.

Contraindications: In individuals with history of allergic reaction to penicillins.

WARNINGS: SERIOUS AND OCCASIONALLY FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS REPORTED IN PATIENTS ON PENICILLIN THERAPY. ALTHOUGH MORE FREQUENT FOLLOWING PARENTERAL THERAPY, ANAPHYLAXIS HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. MORE LIKELY IN INDIVIDUALS WITH HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. BEFORE THERAPY, INQUIRE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS OR OTHER ALLERGENS. IF ALLERGIC REACTION OCCURS, INSTITUTE APPROPRIATE THERAPY AND CONSIDER DISCONTINUANCE OF AMOXICILLIN. **SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. ADMINISTER OXYGEN, INTRAVENOUS STEROIDS AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS INDICATED.**

Usage in Pregnancy: Safety in pregnancy not established.

Precautions: As with any potent drug, assess renal, hepatic and hematopoietic function periodically during prolonged therapy. Keep in mind possibility of superinfections with mycotic or bacterial pathogens; if they occur, discontinue drug and/or institute appropriate therapy.

Adverse Reactions: As with other penicillins, untoward reactions will likely be essentially limited to sensitivity phenomena and more likely occur in individuals previously demonstrating penicillin hypersensitivity and those with history of allergy,

asthma, hay fever or urticaria. Adverse reactions reported as associated with use of penicillins: *Gastrointestinal:* Nausea, vomiting, diarrhea. *Hypersensitivity Reactions:* Erythematous maculopapular rashes, urticaria. **NOTE:** Urticaria, other skin rashes and serum sickness-like reactions may be controlled with antihistamines and, if necessary, systemic corticosteroids. Discontinue amoxicillin unless condition is believed to be life-threatening and amenable only to amoxicillin therapy. *Liver:* Moderate rise in SGOT noted, but significance unknown. *Hemic and Lymphatic Systems:* Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, agranulocytosis. All are usually reversible on discontinuation of therapy and believed to be hypersensitivity phenomena.

Dosage: *Ear, nose, throat, genitourinary tract, skin and soft tissue infections*—Adults: 250 mg every 8 hours. Children: 20 mg/kg/day in divided doses every 8 hours; under 6 kg, 0.5 ml of Pediatric Drops every 8 hours; 6-8 kg, 1 ml of Pediatric Drops every 8 hours. *Lower respiratory tract infections and severe infections or those caused by less susceptible organisms*—Adults: 500 mg every 8 hours. Children: 40 mg/kg/day in divided doses every 8 hours; under 6 kg, 1 ml of Pediatric Drops every 8 hours; 6-8 kg, 2 ml of Pediatric Drops every 8 hours. *Gonorrhea* (acute uncomplicated anogenital and urethral infections)—Males and females: 3 grams as a single oral dose. **NOTE:** Children weighing more than 8 kg should receive appropriate dose of oral suspension 125 mg or 250 mg/5 ml. Children weighing 20 kg or more should be dosed according to adult recommendations.

Note: In gonorrhea with suspected lesion of syphilis, perform dark-field examinations before amoxicillin therapy and monthly serological tests for at least four months. In chronic urinary tract infections, frequent bacteriological and clinical appraisals are necessary. Smaller than recommended doses should not be used. In stubborn infections, several weeks' therapy may be required. Except for gonorrhea, continue treatment for a minimum of 48-72 hours after patient is asymptomatic or bacterial eradication is evidenced. Treat hemolytic streptococcal infections for at least 10 days to prevent acute rheumatic fever or glomerulonephritis.

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EDITORIALS

Highlights of the House of Delegates

In a year of unprecedented problems, your delegates energetically debated, voted, and resolved actions of great importance to all. Details can be found in this issue, but the main points are worthy of emphasis:

Professional Liability Insurance — MSNJ urged the Governor and the Legislature of New Jersey "to enact reasonable and effective remedial legislation" and the Courts of New Jersey "to adopt a rational approach in deciding medical liability cases" within six months or "the physicians of New Jersey (will) be urged to withhold all but emergency medical services." The President, the Board of Trustees, and the Councils on Public Relations and Medical Services will inform the public and physician members of our anticipated action.

Updating Medicare Fees — MSNJ will study and make recommendations to HEW "for changes in Medicare legislation to permit fee allowance changes in a more expeditious and timely fashion."

New Jersey Foundation for Health Care Evaluation — The Foundation has adequate funds for fiscal 1975-1976 (from HEW, MSNJ, and other sources) so no additional MSNJ funds will be given at this time.

Smoking — "RESOLVED that smoking of any material shall be prohibited in all deliberative meetings of all official bodies connected with MSNJ."

MSNJ urged the New Jersey Legislature to pass a law requiring designated restricted smoking areas in all enclosed public gathering places and public transportation vehicles to protect the non-smokers, as well as the smokers, from a health standpoint.

School Child Bus Safety — MSNJ urged Governor Byrne "in the strongest possible terms" to correct the continued lack of safety in the construction of school buses, especially the inadequate body structure and inadequate seating (lack of restraints, insufficient anchorage, and padding).

Doctors Samuel J. Lloyd and David Eckstein — MSNJ expressed "commendation and special thanks for a job well done" to Dr. Lloyd who resigned as Treasurer and to Dr. Eckstein who resigned as Chairman of the Board of Trustees.

Federal Catastrophic Health Insurance — MSNJ urged the AMA, through resolution at the June 1975 convention, to "assume the leadership in the study and promotion of catastrophic health insurance."

Relicensure of Physicians — MSNJ resolved "actively to oppose any legislation or bureaucratic regulation that would require relicensure examination of physicians."

HEW Ruling Concerning Medicare and Medicaid Admissions — MSNJ urged its membership not to participate in the implementation of this regulation (which requires certification within one working day of the necessity of hospital admission) through any utilization committee or otherwise.

Reimbursement to Physicians for Utilization Review Function — MSNJ actively supported "the principle that physicians should be reimbursed for their time devoted to utilization review." A.K.

Society Dues and Medical Complexities

Do you think your medical society dues are high? Is medical practice getting too complicated?

Dr. Richard L. Franklin recently sent us a copy

of a receipt for dues paid by his late uncle, Dr. Louis F. Franklin, to the Hudson County Medical Society for the period January 1, 1907 to December 31, 1907. The amount was \$3. The "admission fee" to the society at that time was \$1.

The Hudson County Medical Society's Constitution and Bylaws stated that "any member who shall fail to pay his annual dues by April 1 shall be held as suspended without action on the part of the Society," while members "more than one year in arrears shall be dropped from the roll of members."

Dr. Louis Franklin was quoted, prior to his death in 1937, as saying of the practice of medicine that "it's getting too complicated for me."

Many of us today feel that the practice of medicine is getting "complicated" — with the major advances in scientific information and technology which face us weekly — but we also feel harassed by such extra-medical complications as malpractice insurance, government intervention, and "consumerism."

Dr. Richard Franklin speculated that his uncle, speaking of the \$3 dues, might have said "it's not worth it; what do I get for it?" With the present dues higher by a factor of a hundred times, the same statement/question is still being posed by some of us.

At least part of the answer to that query is the fact that seventy-five years later there still is a viable Hudson County Medical Society and a Medical Society of New Jersey, which are representing, and fighting for, the physicians who practice medicine in this State. The degree of each physician's representation in 1975, as it probably was in 1907, is at least partially related to the extent to which he makes clear his feelings to his leaders. Let them hear from you. A.K.

¹Tappel A L: Vitamin E. *Nutrition Today* July-August 1973, PP. 4-12

²Evans H M and Bishop K S: Existence of a hitherto unknown dietary factor essential for reproduction. *JAMA* 81:889, September 15, 1923

Vitamin E: Indication Anyone?

The unsupervised, rampant, almost epidemic use of vitamin E by our patients, which is obvious to all physicians, continues unabated while the purveyors of health foods, the self-styled "nutritionists" in the media, and the food faddists among the lunatic fringe continue to pressure the public unmercifully. Amid the free advice is the usual back-handed slap at physicians, individually and collectively, who refuse to acknowledge the purported benefits of vitamin E for human sterility, coronary heart disease, diminished virility, and a host of other health problems.

We physicians, and our colleagues in the field of nutrition, continue to be embarrassed by this situation, while patients expend time and money and delay proper medical diagnosis and treatment by self-medication with wasteful megadoses of vitamin E. In defense, we should be aware of the several specific, undisputed indications for vitamin E therapy:

1. Supplementation of premature infant formulas to prevent hemolytic anemia.
2. Treatment of malnourished patients who are ingesting an unbalanced or inadequate diet.
3. Treatment of patients with malabsorption problems, including cystic fibrosis, hepatic cirrhosis, post-gastrectomy status, obstructive jaundice, pancreatic insufficiency, sprue, and a variety of intestinal conditions.

In addition to the above, there have been scientific reports indicating possible benefit for intermittent claudication. Double-blind studies have shown relief of walking-induced calf pain by the ingestion of 400 mg or more of vitamin E daily for at least three months.¹ Setting aside the human deficiency disorders and peripheral vascular insufficiency, vitamin E's basic function as an antioxidant at the cellular level is essential. Evans and Bishop discovered vitamin E in 1923 and named it "tocopherol."² Half a century later, "apparently the only thing vitamin E lacks is a good indication for its use."¹

A.K.

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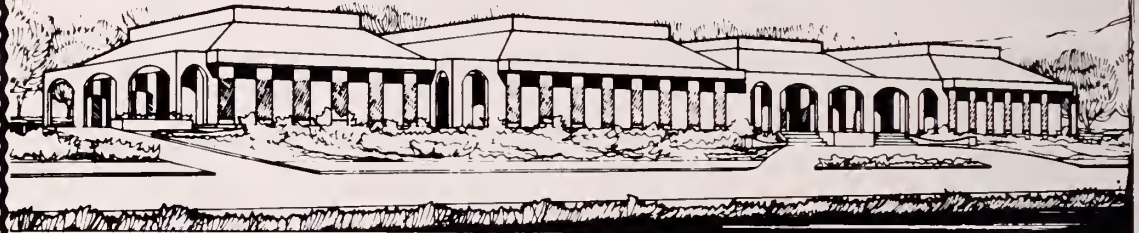
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TRANSACTIONS

1975 House of Delegates

209th ANNUAL MEETING

The Medical Society of New Jersey

May 31-June 3, 1975



President Rogers



President-Elect McGuire



Dr. McGuire, Incoming President, receives Presidential Certificate from President Rogers

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ANNUAL REPORTS

President

James A. Rogers, M.D., Paterson

(Reference Committee "A")

Nineteen hundred seventy-four-nineteen hundred seventy-five was an active year for The Medical Society of New Jersey. It was a year in which this administration took a hard look at the issues before it and planned its course accordingly. Several projects which prior administrations began were continued and a few more projects were introduced. The responsibilities of the various councils and committees have been increased and many have responded well. The challenge to communicate with our critics and our allies in the delivery of health care was addressed and progress can be reported in this area. External forces, including regulatory rules and regulations, public concern embracing the consumer philosophy, payment for service through third parties, the attitudinal change from medical care to total community health care, are such that they require our immediate attention and action. They require our leadership, expertise, and counsel in dealing with the allied health professions in a cooperative manner in seeking solutions to the problems before us. We cannot procrastinate, nor can we afford to continue to argue for an internally oriented service organization, when our task is to provide a necessary and much needed service along with other providers of health care service. The task is to provide quality health care to the entire community at a reasonable cost. It is obvious that single handed, no one group can do it, but together it is possible to accomplish this task.

To this end the following activities were pursued and some additional endeavors were initiated:

1. The Foundation has made tremendous strides in its short existence, addressing itself to the peer review question. It has accomplished much in helping the local PSROs to get started in keep-

ing them informed of the rapidly changing world of rules and regulations. It is working cooperatively with involved groups in a much-needed educational program in the utilization review processes for our hospital medical staffs. The Foundation is also addressing itself to new systems which will affect the way in which physicians may be involved in the delivery of medical care. Only a few points have been discussed on this worthy project. The report made by the Foundation itself will go into greater detail. The mention in this report is to support strongly the Foundation as a vital and necessary peer review arm of the Medical Society.

2. The Academy of Medicine, which is the educational arm of The Medical Society of New Jersey has demonstrated an admirable record of accomplishments. It has become a progressive and viable organization which has responded to the challenge of continuing medical education. It deserves our support and our backing and must continue to be strongly affiliated with the Medical Society. The Academy must be encouraged to broaden its activities in continuing education for the practicing physician at all levels.

3. In the past few years the relationship between the College of Medicine and Dentistry of New Jersey and the Medical Society has grown stronger. The avenues of communication and mutual cooperation have increased. Dialogue on issues vital to both has increased and both must do all in their power to continue this bonded relationship.

4. This past year our rapport with the New Jersey Hospital Association has been closer. Avenues of communication and cooperation have increased. Meetings and a mutual exchange of ideas have demonstrated progress in the

challenges that are facing us both. We now realize that we can and must approach common issues together.

5. Our joint conferences with the New Jersey State Nurses' Association continue to produce understanding between our two professions and progress is evident in the programs under way. Perhaps the encouragement and formation of joint conferences between physicians and nurses at a local level is a good beginning. From here other programs can be initiated and accomplished.

6. On several occasions we have met with representatives of the New Jersey Bar Association. A program has been outlined to bring the two organizations closer together to find solutions to the many problems that confront the physicians and the attorneys in their areas of involvement. Both organizations support the concept that through dialogue, discussion, and understanding we can avoid many of the problems that face us today. It has become evident that education is needed for both groups. Our meetings with the Judiciary and the Bar are more productive and at the most recent meeting it was a unanimous decision that more such meetings should be held until we have resolved the many problems that exist. It was encouraging to sense the cooperative spirit displayed by all the participants at these meetings.

7. It is a pleasure to report on the fine rapport and liaison that exists between the Woman's Auxiliary and the Medical Society. The Woman's Auxiliary has been active in many vital areas and has made great progress. It is a comfort to have them by our side both singularly and as a group.

8. Another issue that this administration and the Committee on Annual Meeting addressed itself

to was the question of Haddon Hall as a convention site. It is indeed unfortunate that after so many years a change had to be made. Following the increasing number of complaints that were being compounded annually over the past few years, a meeting was held with the people in Haddon Hall, and unfortunately, the problems could not be satisfactorily resolved. A search for a new meeting place brought us to Cherry Hill. This was thoroughly investigated and the decision to hold the 1975 Annual Meeting was made. The Committee on Annual Meeting and staff have labored diligently and long to make this a success. It is important to note that this Annual Meeting will be the first to host "The Annual Governor's Conference on Health Affairs." Prominent authorities in the health care field will address issues of importance, not only to the physician but to the public at large. This conference must continue annually to keep us informed of the broad issues of health care in which we are all involved.

Our discussion here has been necessarily limited to the innovative programs to which this administration has addressed itself. The progress made by the important councils and committees of The Medical Society of New Jersey is presented in the respective reports.

In closing I would like to add the personal observation that the task of the Medical Society and the responsibilities of your administration and your Board of Trustees increases each year. They deserve your support, cooperation, and input. As physicians you should recognize that in these times unity at all levels is essential to the continued growth and functioning of organized medicine.

Filed (page Tr 114)

1974 TRANSACTIONS

At its first session on Saturday, May 31, 1975, the House of Delegates approved the Transactions of the 1974 House of Delegates as published in the July 1974 issue of THE JOURNAL and distributed to the membership.

Secretary

Charles L. Cuniff, M.D., Jersey City

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1974)

Active: Paid	7,770
Exempt	650 8,420*
†Associate: Paid	0
**Affiliate: Paid	28
State Emeritus	375
Total of Above	8,823
State Honorary	8
New and Reinstated Members:	
Active	653
†Associate	0
**Affiliate	1
Transfers within the state	27
Transfers out-of-state and resignations	114
Members deceased	102
Members dropped:	
Active (non-payment of dues)	50
(N.J. licensure revoked)	2
(N.J. licensure suspended)	2
(N.J. licensure voluntarily surrendered)	2
†Associate (non-payment of dues)	0 56

*Adjusted for transfers out-of-state, resignations, and deaths.

†Associate membership (non-licensed in N.J.) designates Interns and Residents.

**Affiliate membership — physicians who no longer practice in New Jersey.

AMA MEMBERSHIP

A total of 6,386 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates has risen to a total of seven delegates — one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

In October 1974, the completion of the 1974-75 edition of the *Membership Directory* was announced. Distribution to the entire membership was made the same month.

Basically the new *Directory* embodied the same features as that of the 1972-73 edition, which includes:

The supplement section — available only in copies prepared for members — contains the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners, Guides for Physician-Hospital Relationships in New Jersey, and a list of Poison Control Centers in New Jersey.

Again, an expression of gratitude is in order for the cooperation received from the membership in assisting us to produce this *Directory*.

Filed (page Tr 116)

ACTION TO LIMIT DEBATE

At its first session on Saturday, May 31, 1975, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject, except by express permission of the House; and that the time be limited to four minutes per speaker, subject to the same exception.

Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")

This 1975 interim financial report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey.

The Balance Sheet is presented as of March 31, 1975 and May 31, 1974. Figures at March 31, 1975 have not been audited, for the reason that the fiscal year of the Society does not end until May 31, 1975. The figures at May 31, 1974 have been abstracted from the report of audit dated July 31, 1974.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated presents the transactions of the Society for the ten months ended March 31, 1975 and the year ended May 31, 1974.

Revenues have been examined on a test basis and disbursements have been test checked to ap-

proved supporting vouchers by the Society's independent accountants. The cash balances at March 31, 1975 were reconciled with the bank statements but were not confirmed direct with the depositories. Revenues from Counties for dues assessments were checked in detail to reports on file, but were not confirmed with County Treasurers at this time. Investments were not physically examined or confirmed at March 31, 1975.

These financial statements have been prepared in a form similar to the annual audit report, in order to show in greater detail the assets, liabilities, and fund balance, operating revenue and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

Filed with commendation to the Treasurer (page Tr 117)

BALANCE SHEET — GENERAL FUND

	March 31, 1975 (Unaudited)	May 31, 1974 (Audited)
Assets		
Cash (Overdraft) (Page Tr 14)	\$ (44,325.18)	\$ 77,444.57
General Fund Investment Account — at cost (Page Tr 14)	546,704.00	334,101.40
General Fund Investment Portfolio — at cost (Page Tr 15)	189,780.44	188,141.90
General Fund Saving Certificates (Page Tr 15)	40,000.00	30,000.00
Accounts Receivable	10,835.72	25,727.09
Inventories — at cost		
Maternity Service Record Books	5,217.08	6,040.12
"The Healing Art" Books	3,754.16	3,772.40
Land, Building and Equipment — at cost	326,282.53	326,282.53
Deferred Expense — Construction Loan	64,500.00	72,000.00
Accrued Interest	11,593.36	4,633.46
Other Assets	10.60	597.31
	<u>\$1,154,352.71</u>	<u>1,068,740.78</u>

LIABILITIES AND FUND BALANCES

Liabilities:		
Unexpended Budget Appropriations (Page Tr 10)	\$ 149,308.17	\$ ———
Accounts Payable	11,120.56	57,770.89
Payroll Taxes Payable	2,353.10	509.30
AMA Collection Fees Payable	799.29	4,850.45
Due to Physicians' Relief Fund	39,797.81	40,902.75
Due to Medical Student Loan Fund	64,500.00	72,000.00
Due to N.J. Foundation for Health Care Evaluation	10,450.00	———
Deferred Income — Assessments Collected		
Applicable to Succeeding Year (Page Tr 13)	307,745.94	352,339.90
AMA Voluntary Collection	7,095.00	———
Other Liabilities	921.40	———
Funds for Specific Purposes:		
House Restoration and Replacement	9,339.24	7,339.24
Land, Building and Equipment	326,282.53	326,282.53
Maternity Service Record Books	5,217.08	6,040.12
Royalties on "The Healing Art"	925.50	930.00
"The Healing Art" Books	2,828.66	2,842.40
Membership Directory	4,073.26	2,531.52
Annual Meeting	14,666.76	———
Training Program for Emergency Physicians & Nurses	2,934.13	———
Renovation of Caretaker's Residence	3,200.00	———
General Fund Balance (Unappropriated)	190,794.28	194,401.68
	<u>\$1,154,352.71</u>	<u>\$1,068,740.78</u>

STATEMENT OF REVENUE, EXPENDITURES AND GENERAL FUND BALANCE (UNAPPROPRIATED)

	Ten Months Ended March 31, 1975 (Unaudited)	Year Ended May 31, 1974 (Audited)
Revenue:		
Assessments Earned (Page Tr 13)	\$610,563.46	\$547,191.35
Interest Income from General Fund		
Investments (Page Tr 14)	13,649.83	12,329.59
Interest Income from General Fund		
Savings Certificates (Page Tr 15)	1,147.25	1,554.13
Interest Income from General Fund		
Investment Portfolio (Page Tr 15)	12,339.03	11,168.59
Maternity Service Record Book Sales	823.04	746.20
"The Healing Art" Book Sales	25.50	59.50
Interest Income on AMA Dues	———	8,238.29
Total Revenue	\$638,548.11	\$581,287.65
Expenditures — Budget Appropriations		
(12 Months) — (Page Tr 10)	\$609,872.00	\$528,662.86
Excess of Revenue over Expenditures before Medical Journal Deficit and Miscellaneous Expenditures	\$ 28,676.11	\$ 52,624.79
Other Decreases:		
Medical Journal Deficit (Page Tr 12)	\$ 31,560.20	\$ 22,843.05
Annual Meeting Deficit	———	8,706.43
Prior Year's Expenditures paid in Current Year	723.31	992.79
Publication Cost of Current Maternity Service Record Book	———	6,107.36
	<u>\$ 32,283.51</u>	<u>\$ 38,649.63</u>
New Increase (Decrease) in Fund Balance (Unappropriated) from Operations	\$ (3,607.40)	\$ 13,975.16
General Fund Balance (Unappropriated):		
Balance, Beginning	<u>\$194,401.68</u>	<u>\$180,426.52</u>
Balance, Ending	<u>\$190,794.28</u>	<u>\$194,401.68</u>

STATEMENT OF EXPENDITURES — GENERAL FUND
FOR THE TEN MONTHS ENDED MARCH 31, 1975
(UNAUDITED)

Account	Adopted Budget	Total Expended	Balance Unexpended
Executive Salaries	\$ 98,485.50	\$ 80,523.64	\$ 17,961.86
General Staff Salaries	192,882.75	150,694.15	42,188.60
General Executive Office Expenses	27,000.00	25,348.56	1,651.44
Executive Travel	4,700.00	3,348.22	1,351.78
House Maintenance	30,500.00	23,150.13	7,349.87
Treasurer	8,400.00	7,305.52	1,094.48
Finance and Budget Committee	75.00	-----	75.00
Secretary	400.00	-----	400.00
Salary Taxes	17,128.75	12,581.32	4,547.43
Insurance	14,000.00	14,680.29	(680.29)
House Reserve	10,000.00	5,860.27	4,139.73
MSNJ Pension Plan	2,200.00	1,964.62	235.38
MSNJ Building Loan	14,100.00	11,099.56	3,000.44
Legislation	8,500.00	4,265.88	4,234.12
Council on Public Health	3,300.00	1,480.78	1,819.22
Council on Public Relations	37,000.00	14,666.20	22,333.80
Council on Medical Services	750.00	121.53	628.47
Council on Mental Health	1,700.00	429.71	1,270.29
President and Presidential Officers	16,300.00	15,285.20	1,014.80
AMA Delegates	19,320.00	17,655.17	1,664.83
Woman's Auxiliary	6,680.00	5,215.63	1,464.37
Committee on Medical Education	30,500.00	23,285.65	7,214.35
Conference Groups	500.00	271.75	228.25
Membership Directory	21,600.00	21,600.00	-----
Committee on Emergency Medical Care	7,900.00	275.76	7,624.24
Credentials & Membership Committee	1,200.00	781.76	418.24
Committee on Medical Defense & Insurance	700.00	206.13	493.87
Membership Inq. & Complaint Committee	1,000.00	14.40	985.60
Board of Trustees	8,500.00	3,874.29	4,625.71
Contingent	10,000.00	7,541.74	2,458.26
Judicial Council	500.00	496.46	3.54
Legal	3,550.00	1,289.23	2,260.77
Medical Student Loan Fund	6,000.00	-----	6,000.00
Authorized Reimbursement for Representatives to Meetings	4,500.00	5,250.28	(750.28)
Total Budget Expenditures	<u>\$609,872.00</u>	<u>\$460,563.83</u>	<u>\$149,308.17</u>

BALANCE SHEET
PHYSICIANS' RELIEF FUND

Assets	Ten Months Ended March 31, 1975 (Unaudited)	Year Ended May 31, 1974 (Audited)
Cash (Page Tr 14)	\$ 1,550.00	-----
Due from General Fund	39,797.81	40,902.75
Fund Balance	<u>\$41,347.81</u>	<u>\$40,902.75</u>

STATEMENT OF REVENUE AND FUND BALANCE
PHYSICIANS' RELIEF FUND

	Ten Months Ended March 31, 1975 (Unaudited)	Year Ended May 31, 1974 (Audited)
Revenue:		
Income from Investments	\$ 1,895.06	\$ 2,315.25
Contributions	50.00	-----
Total Revenue	\$ 1,945.06	\$ 2,315.25
Grants (Expense)	1,500.00	-----
Net Revenue	\$ 445.06	\$ 2,315.25
Fund Balance, Beginning	\$40,902.75	\$38,587.50
Fund Balance, Ending	<u>\$41,347.81</u>	<u>\$40,902.75</u>

BALANCE SHEET
MEDICAL STUDENT LOAN FUND

	Ten Months Ended March 31, 1975 (Unaudited)	Year Ended May 31, 1974 (Audited)
Assets		
Cash (Page Tr 14)	\$ 2,771.05	\$ 4,531.58
Certificates of Deposit (Page Tr 15)	85,000.00	-----
General Investments — at cost (Page Tr 15)	29,532.00	111,594.55
Notes Receivable — Secured by		
Life Insurance Policies Assigned	247,844.00	226,404.00
Due from General Fund	64,500.00	72,000.00
Accrued Interest	1,447.07	1,405.34
Loans Receivable — General Fund	11,099.56	13,860.00
Fund Balance	<u>\$442,193.68</u>	<u>\$429,795.47</u>

Note: The Fund balance includes \$7,362 designated as the Albert Barker Kump Memorial Grant and \$5,055 designated as the Joseph E. Mott Memorial Grant.

STATEMENT OF REVENUE AND FUND BALANCE
MEDICAL STUDENT LOAN FUND

	Ten Months Ended March 31, 1975 (Unaudited)	Year Ended May 31, 1974 (Audited)
Revenue:		
Contributions:		
General	\$ 1,550.27	\$ 4,725.30
Albert Barker Kump Memorial Grant	250.00	250.00
General Fund Contribution	-----	6,000.00
Income from Investments	6,628.47	6,569.89
Income on Certificates of Deposit	-----	-----
Interest on Notes Receivable	279.95	549.39
Interest on Loans Receivable — General Fund	3,599.56	4,860.00
Bad Debts Recovery	89.96	15.00
Miscellaneous Income	-----	2.56
Total Revenue	\$ 12,398.21	\$ 22,972.14
Bad Debts Expense	-----	400.00
Net Revenue	\$ 12,398.21	\$ 22,572.14
Fund Balance, Beginning	\$429,795.47	\$407,223.33
Fund Balance, Ending	<u>\$442,193.68</u>	<u>\$429,795.47</u>

STATEMENT OF REVENUE AND EXPENDITURES
MEDICAL JOURNAL

	Ten Months Ended March 31, 1975 (Unaudited)	Year Ended May 31, 1974 (Audited)
Revenue:		
Members' Subscriptions Earned	\$ 34,254.25	\$ 37,991.25
Advertising:		
State Medical Journal Advertising Bureau	28,172.35	34,581.72
Local	15,353.72	15,123.05
Classified	565.60	430.90
Cooperative Rebate	1,091.92	762.08
Subscriptions and Extra Copies	1,824.78	1,587.48
Reprints — Net	692.00	602.52
Illustrations	748.01	824.23
 Total Revenue	 \$ 82,702.63	 \$ 91,903.23
Expenditures:		
Publication	\$ 75,519.73	\$ 72,340.25
Salaries	24,086.81	24,904.48
Advertising Manager's Commission	5,000.00	5,303.83
Commissions — Local	5,695.35	6,225.84
Discounts	674.36	842.22
Administrative Expenses	—	579.53
Payroll Taxes	1,608.15	1,690.57
Insurance	25.00	106.74
Travel	346.26	109.04
Illustration Expenses	1,221.68	1,501.08
Office Expenses	85.49	1,142.70
 Total Expenditures	 \$114,262.83	 \$114,746.28
Excess of Expenditures over Revenue	\$ 31,560.20	\$ 22,843.05

SCHEDULE OF STATE ASSESSMENTS COLLECTED
FOR THE TEN MONTHS ENDED MARCH 31, 1975
(UNAUDITED)

County	1975 Dues	1974 Dues	Net State Assessments
Atlantic	\$ 14,000.00	\$ 310.00	\$ 14,310.00
Bergen	90,200.00	4,050.00	94,250.00
Burlington	17,660.00	1,170.00	18,830.00
Camden	45,020.00	1,270.00	46,290.00
Cape May	3,500.00	200.00	3,700.00
Cumberland	10,100.00	400.00	10,500.00
Essex	126,360.00	6,835.00	133,195.00
Gloucester	9,300.00	365.00	9,665.00
Hudson	29,260.00	7,030.00	36,290.00
Hunterdon	5,300.00	100.00	5,400.00
Mercer	22,600.00	13,330.00	35,930.00
Middlesex	38,120.00	465.00	38,585.00
Monmouth	38,320.00	3,715.00	42,035.00
Morris	33,920.00	900.00	34,820.00
Ocean	13,100.00	1,735.00	14,835.00
Passaic	57,420.00	1,185.00	58,605.00
Salem	3,600.00	—	3,600.00
Somerset	7,820.00	1,635.00	9,455.00
Sussex	6,300.00	155.00	6,455.00
Union	61,740.00	1,835.00	63,575.00
Warren	5,700.00	610.00	6,310.00
 Total	 \$639,340.00	 \$47,295.00	 \$686,635.00

RECONCILIATION OF STATE ASSESSMENT ACCOUNT
FOR THE TEN MONTHS ENDED MARCH 31, 1975
(UNAUDITED)

Unearned Assessments, June 1, 1974	\$352,339.90	
Collections — 1974 Members' Dues	\$ 47,295.00	
Less: Annual Meeting Assessment	\$ 1,163.75	
Medical Journal Assessment	2,319.25	
N.J. Foundation for Health		
Care Evaluation Assessment	<u>5,410.00</u>	
	\$ 8,893.00	
		\$ 38,402.00
Collections—1975 Members', Associate & Affiliate Members' Dues	\$639,340.00	
Less: Annual Meeting Assessment	\$15,967.50	
Medical Journal Assessment	31,935.00	
N.J. Foundation for Health		
Care Evaluation Assessment	<u>63,870.00</u>	
	\$111,772.50	
	\$527,567.50	
Less: 1975 Assessment Applicable to Year Ending May 31, 1976 — (\$527,567.50 × 7/12)		\$307,745.94
		<u>\$219,821.56</u>
Earned Assessments for the Ten Months Ended March 31, 1975		<u>\$610,563.46</u>

SCHEDULE OF SPECIAL ASSESSMENTS COLLECTED
FOR THE TEN MONTHS ENDED MARCH 31, 1975
(UNAUDITED)

County	American Medical Association Dues
Atlantic	\$ 13,530.00
Bergen	82,775.00
Burlington	15,750.00
Camden	45,650.00
Cape May	3,630.00
Cumberland	8,910.00
Essex	127,600.00
Gloucester	9,460.00
Hudson	27,830.00
Hunterdon	5,280.00
Mercer	33,990.00
Middlesex	33,880.00
Monmouth	24,310.00
Morris	24,860.00
Ocean	10,505.00
Passaic	36,850.00
Salem	3,630.00
Somerset	6,600.00
Sussex	3,960.00
Union	58,080.00
Warren	<u>6,270.00</u>
Total	<u>\$583,350.00</u>

RECONCILIATION OF SPECIAL ASSESSMENTS
FOR THE TEN MONTHS ENDED MARCH 31, 1975
(UNAUDITED)

	American Medical Association
Balance Payable, June 1, 1974	\$ 3,300.00
Assessments Collected per above	583,350.00
	<hr/>
Remitted to AMA	\$586,650.00
	586,650.00
	<hr/>
Balance Payable, March 31, 1975	\$ <u>-----</u>

ANALYSIS OF CASH, CERTIFICATES OF DEPOSIT, INVESTMENTS AND INCOME THEREON
MARCH 31, 1975
(UNAUDITED)

General Fund:

New Jersey National Bank:

Treasurer's General Checking (Overdraft)	\$(69,325.18)
Executive Account Checking	24,500.00
Office Petty Cash Fund	500.00
	<hr/>
Total (Overdraft)	\$(44,325.18)

Medical Student Loan Fund:

New Jersey National Bank:

Treasurer's Checking Account	\$ 2,771.05
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Physicians' Relief Fund:

New Jersey National Bank:

Treasurer's Checking Account	\$ <u>1,550.00</u>
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ANALYSIS OF GENERAL FUND INVESTMENTS AND INCOME THEREON
MARCH 31, 1975
(UNAUDITED)

	Due Date	Cost	Maturity Value	Yield	Interest Income
New Jersey National Bank:					
Certificate of Deposit					
#242495	5/06/75	\$ 40,000.00	\$ 40,000.00	5.5%	\$ 323.88
#242500	5/13/75	40,000.00	40,000.00	5.5%	281.11
#242522	5/27/75	30,000.00	30,000.00	5.5%	151.22
#5174	4/07/75	150,000.00	150,000.00	5.875%	611.58
#5189	6/18/75	50,000.00	50,000.00	5.5%	76.38
#5181	6/11/75	40,000.00	40,000.00	5.5%	110.00
U.S. Treasury Bill	4/01/75	49,135.00	50,000.00	6.963%	865.00
U.S. Treasury Bill	4/01/75	68,783.00	70,000.00	6.963%	1,217.00
U.S. Treasury Bill	4/10/75	39,337.80	40,000.00	6.698%	589.42
U.S. Treasury Bill	5/01/75	39,448.20	40,000.00	5.606%	367.83
		<hr/>	<hr/>		
		\$546,704.00	\$550,000.00		\$ 4,593.42
<hr/>					
Income from Investments Redeemed During Period					\$10,951.47
					<hr/>
Less: Interest Income on Physicians' Relief Fund					\$15,544.89
					<hr/>
General Fund Investment Income					\$ <u>1,895.06</u>
					<hr/>
					<u>\$13,649.83</u>

ANALYSIS OF GENERAL FUND SAVINGS CERTIFICATES AND INCOME THEREON
MARCH 31, 1975
(UNAUDITED)

	Cost	Rate of Interest	Interest Income
Trenton Savings Fund:			
Certificate #10-8427	\$20,000.00	6%	\$ 203.33
Certificate #11-8428	<u>20,000.00</u>	6.75%	<u>228.75</u>
	<u>\$40,000.00</u>		432.08
Income from Certificates Redeemed During Period			<u>715.17</u>
General Fund Savings Certificate Income			<u>\$1,147.25</u>

ANALYSIS OF INVESTMENT PORTFOLIO AND INCOME THEREON
MARCH 31, 1975
(UNAUDITED)

Description	Due Date	Yield to Maturity	Cost	Maturity Value	Interest Income
Fed. Nat'l Mortgage Assoc.	6/10/75	5.25%	\$ 20,000.00	\$ 20,000.00	\$ 810.48
Federal Land Bank	7/21/75	8.3%	39,825.00	40,000.00	2,978.54
Federal Intermediate Credit Bank	4/01/75	9.25%	50,000.00	50,000.00	3,468.75
Federal Intermediate Credit Bank	6/02/75	9.8%	19,992.94	20,000.00	1,142.68
Federal Home Loan Bank	5/25/76	7.2%	19,962.50	20,000.00	387.05
Federal Home Loan Bank	5/25/76	7.2%	<u>40,000.00</u>	<u>40,000.00</u>	<u>337.94</u>
			<u>\$189,780.44</u>	<u>\$190,000.00</u>	\$ 9,125.44
Income from Investments Redeemed During Period					<u>3,213.59</u>
Total Interest Income from Investment Portfolio					<u>\$12,339.03</u>

ANALYSIS OF MEDICAL STUDENT LOAN FUND INVESTMENT ACCOUNT
AND INCOME THEREON
MARCH 31, 1975
(UNAUDITED)

	Due Date	Yield to Maturity	Cost	Maturity Value	Interest Income
New Jersey National Bank:					
Certificate of Deposit					
#242494	5/07/75	5.5%	\$ 15,000.00	\$ 15,000.00	\$ 121.44
#242520	5/28/75	5.5%	15,000.00	15,000.00	73.32
#5188	6/18/75	5.5%	5,000.00	5,000.00	8.40
#5197	6/25/75	5.5%	50,000.00	50,000.00	30.53
U.S. Treasury Bill	4/24/75	6.369%	<u>29,532.00</u>	<u>30,000.00</u>	<u>348.38</u>
			<u>\$114,532.00</u>	<u>\$115,000.00</u>	\$ 582.07
Income from Investments Redeemed During Period					<u>6,046.40</u>
Total Interest from Investments					<u>\$6,628.47</u>

Board of Trustees

David Eckstein, M.D., Chairman, Trenton

(Reference Committee "A")

All significant actions taken by the Board of Trustees at regular meetings held in the course of the year now closing have been reported in *The Journal* and have thus been called to the attention of the general membership. In addition, full copies of all Board minutes are transmitted to the presidents, secretaries, and executive secretaries, for reference and report at county meetings. In this report, therefore, it seems necessary and desirable to emphasize by specific mention only those items of particular significance that are not reflected elsewhere in the individual reports of councils and committees.

Filed (page Tr 114)

AMA DELEGATION (Reference Committee "A")

On January 22, 1975, MSNJ was advised that because of the increase of AMA membership in New Jersey during the 1974 calendar year, the Society is entitled to another delegate. Notification was to be transmitted to the AMA by January 29. Because of this emergent status, this matter was processed through the Executive Committee which named George L. Benz, M.D., to the newly-created post.

These events created two vacancies in the alternate delegates section, both of which will be filled at the 1975 Annual Meeting, to be effective January 1, 1976.

Subsequently, we were advised by Dr. Sammons that Illinois, California, and Florida had also acquired additional delegates, thus expanding the AMA House of Delegates to 251. The AMA Bylaws provide for reapportionment whenever the size of the House reaches 250.

The Speaker and Vice-Speaker will, however, recommend to the Committee on Credentials for the 1975 Annual and Clinical Sessions that the House approve the seating of the 251 by means of a suspension of the rules, and it is anticipated that the House will act accordingly.

Filed (page Tr 114)

AMA FINANCIAL CRISIS (Reference Committee "A")

The Executive Committee of MSNJ, realizing that the financial crisis of the AMA is very real indeed, authorized a solicitation of the membership for a voluntary giving of at least \$5.00 to afford some relief. This action was taken in the spirit of fellowship and pragmatism. As of April 1, 607 contributions have been made, amounting to \$7,305.

Filed (page Tr 114)

ESTABLISHMENT OF A PHYSICIANS' BILL OF RIGHTS (Reference Committee "A")

This resolution was adopted by the 1974 House of Delegates and referred to the AMA Delegation for drafting of an appropriate resolution after conference with the sponsor, to be submitted to the 1974 Clinical Session of the AMA.

A similar resolution was presented to the AMA House at the 1973 Clinical Session, Resolution #19 (C-73), and was referred to the Council on Medical Service for study and report. The Council recommended to the 1974 AMA House of Delegates that the resolution be "not adopted" because "any attempt to enumerate the rights of physicians in one document would inevitably result in the omission of particular rights which by custom and tradition have been recognized unquestionably as the right and privilege of practicing physicians."

Additionally, the Oklahoma Delegation to the AMA sponsored Resolution #17, "Physicians' Bill of Rights" (A-1974), which is a well-drafted document of the same nature.

At its meeting on July 21, 1974, the Board directed that MSNJ activity in this regard be contingent upon the action of the AMA House on the Report of Reference Committee "A" (A-74).

At the 1974 Clinical Session of the AMA House of Delegates this topic was again discussed and the House again concurred in the recommenda-

tion of the Council on Medical Service, cited above, that no resolution should be adopted.

(Filed (page Tr 115)

MSNJ BOARD MEETINGS — INVITED GUESTS (Reference Committee "A")

The Board continued its precedent of inviting the presidents of the component societies to regular Board meetings on a rotating basis. Executive secretaries of component societies were also invited to attend the sessions of the Board simultaneously with their presidents.

In addition, the Board also sponsored conferences for presidents and presidents-elect of component societies in the fall and spring.

Filed (page Tr 115)

NEW JERSEY HOSPITAL ASSOCIATION (Reference Committee "A")

During the past year, MSNJ's and the New Jersey Hospital Association's Executive Committees have been meeting on a monthly basis to discuss problems of mutual concern.

In November, the Board of Trustees also voted to extend an invitation to the New Jersey Hospital Association to designate one of its elected trustees as a representative to attend MSNJ Board meetings. Jack W. Owen, President of the New Jersey Hospital Association, was designated by NJHA to serve in this capacity for one year.

Filed (page Tr 115)

SPECIAL COMMITTEE ON LONG RANGE PLANNING AND DEVELOPMENT (Reference Committee "A")

Under the Chairmanship of William J. D'Elia, M.D., the Special Committee on Long Range Planning and Development has held six meetings during the 1974-75 administrative year.

The Committee began its schedule of meetings with an extensive discussion of how it would approach the problems of long range planning and the identification of challenges facing MSNJ and the establishment of objectives that would respond to those challenges.

The Committee has been reviewing a resource document from the AMA on long range planning and decided it would use this document as a guide in setting up challenges and objectives for MSNJ. Within the next year the Committee will be establishing priorities within these areas for eventual presentation to the Board of Trustees.

The Board of Trustees has also charged the Committee with the responsibility of studying, evaluating, and suggesting amendments to MSNJ's Committee on Revision of Constitution and Bylaws in order to effect a concise, viable, and responsive organizational document. This report is to be submitted to the Board no later than September 8, 1975.

This assignment to the Committee was the result of a referral from the Board indicating that the organizational documents of the Society are overly prolix, unduly rigid, and resistant to change. These documents do not permit a rapid and effective response to the membership so that a true feeling of ownership and direction can be effected among the membership. Currently, the Standing Committee on Revision of Constitution and Bylaws cannot initiate change or recommendations for change, but can only act as draftsman and commentator on specific proposals presented to it. Such a posture does not truly service the membership and the entire area needs in-depth and thoughtful study.

An important area of revision lies within the section on Amendments to the Constitution. Under the current situation, an amendment to the Constitution can only be accomplished after two years. It was, therefore, agreed by the Committee that before any other revisions were suggested the Committee would work to change this current procedure.

Since an amendment to the Constitution cannot be initiated by a Committee, Doctor Alessi, a member of the Committee and President of the Bergen County Medical Society, offered to prepare an amendment for submission to the House from Bergen County. This amendment will be presented at the 1975 Annual Meeting through the report of the Standing Committee on Revision of Constitution and Bylaws.

The Committee has also discussed the necessity of MSNJ's being able to sense the needs of the membership and the importance of involving county and specialty societies in the development and implementation of the Society's programs and goals. In view of this position, the Committee offered the following recommendations to the Board, which it subsequently endorsed:

(a) That component societies establish a responsible executive staff position, to be filled by a physician or layman, whose duty it would be to represent the county at all relevant, pertinent, or required State Society meetings to garner information and to disseminate that information at county level in order to elucidate important issues in the hope that a more enlightened membership may be developed. (It is recognized that some counties may have to be regionalized, since they may not be able to underwrite the cost entailed.)

(b) That the quarterly meetings for component society executives held at MSNJ be expanded to include staff personnel of specialty societies and the Academy of Medicine of New Jersey, as well as the President of MSNJ and the Chairman of MSNJ's Board of Trustees.

(c) That component societies encourage participation and representation of local hospital medical staffs in their society functions.

The possibility of MSNJ's developing a "Litigation Fund" was also referred to the Board of Trustees for consideration. This fund would be used to litigate the increasing number of rules, regulations, and legislation which are imposing illegal and unconstitutional restrictions on the practice of medicine. This recommendation has been referred to the Committee on Finance and Budget for further study.

In the area of physician-hospital relations, the Committee has referred the Guidelines for Physician-Hospital Relationships, which was adopted by the 1964 House of Delegates, to the Joint Executive Committees of MSNJ and the New Jersey Hospital Association for possible updating and revision.

Filed (page Tr 115)

STATE BOARD OF MEDICAL EXAMINERS (Reference Committee "A")

At its November 17, 1974 meeting, the Board met in executive session and directed the President and the Chairman of the Board to appoint a physician-observer to attend the stated monthly meetings of the State Board of Medical Examiners.

The Chairman of the Board reported (at the December meeting) that upon discussing this matter with the President, the opinion was reached that no one member of MSNJ's Board should attend the meetings of the State Board, but rather that attendance be on a rotation basis. This would allow all members of the Society's Board to observe the actions of the State Board.

Filed (page Tr 115)

UNIFIED AMA MEMBERSHIP (Reference Committee "A")

Meeting in Special Session on December 8, 1974, the House of Delegates adopted, by a vote of 167 to 138 a resolution calling upon MSNJ and each of its federated county societies strongly to recommend that each of their members also be a member of, and support the activities of, the AMA.

As a result of this action, the Board established a Committee on AMA Membership Development and sent a memorandum to the presidents and executive secretaries of component societies inquiring as to how they were implementing the resolution.

Individual counties have responded favorably to the Board's memorandum and indications are that AMA membership over last year's figures is increasing.

Filed (page Tr 115)

EVALUATION OF THE NEW JERSEY FOUNDATION FOR HEALTH CARE EVALUATION (Reference Committee "B")

Resolution #6, "Evaluation of the New Jersey Foundation for Health Care Evaluation," which was adopted, as amended, by the 1974 House of Delegates, called for the Society to re-examine and re-evaluate the function and scope of the New Jersey Foundation for Health Care Evaluation and its relationship to The Medical Society of New Jersey.

On January 22, 1975, a meeting was held between the Executive Committee of MSNJ and that of the Foundation at which time an in-depth study and review were initiated.

the purposes of the Foundation are, generally stated, as follows:

- a. Promote, foster, and develop the availability of quality health care, either alone or in conjunction with individuals, doctors, hospitals, schools, or corporations, organizations, foundations, funds, institutions, or governmental bodies.
- b. Promote, develop, and establish standards for quality care based upon the professionally recognized practices of physicians licensed and practicing in New Jersey.
- c. Promote, organize, and operate peer review activities that provide objectivity in dealing with health care costs, assist in determining medical necessity, and proper utilization of services encompassing the total health needs of patients according to professionally established standards.
- d. Promote, foster, and coordinate the involvement of the health professions in development and evaluation of activities directed to relieving acute manpower shortages, improving the availability of preventive services and expanding the availability of appropriate ambulatory care as an alternative to institutional services and to provide information concerning these activities to individuals, doctors, hospitals, schools, foundations, institutions, governmental bodies, corporations, and the general public.
- e. Promote, develop, and coordinate involvement by the health professions in comprehensive health care planning.
- f. Assist in the development and establishment of acceptable standards for comprehensive health insurance coverage.
- g. Assist in the implementation of Public Law 92-603 as it relates to professional standards review organizations.

Admittedly, these purposes are broad but that is a practical necessity. The role of the Foundation as a PSRO support center is widely understood by Society members. But, its possible functioning in a non-PSRO role is poorly understood.

The Foundation has become the hub of true peer review in New Jersey and given the proper direction and support, it can and will become an organization of vital importance to all members of MSNJ.

The Standards of Criteria developed over the last year have been distributed to all New Jersey hospitals and a plan for prospective and concurrent review was developed for the Medicaid Program but was not implemented.

The Foundation can function as the strong right arm of The Medical Society of New Jersey in forestalling incursions of the State Department of Health and other lay-oriented groups into

"cost only" utilization and peer review. It can and is studying the HMO concept and prepaid plans in regard to evolving patterns of delivery systems. Given the opportunity it could enter the area of claims review thus assuring the physician that his services will be evaluated by a competent, practicing professional.

The objects and purposes of the Foundation are compatible with those of the Society and the working relationship has not only been one of mutual satisfaction but has been typified by a pleasantly cooperative spirit. Obviously, by expanding staff and facilities the Society could perform many, if not most, of the functions of the Foundation, but, not with the same degree of intensity nor, as we are advised by MSNJ staff, at a more reasonable expenditure.

At its March 16 meeting, the Board of Trustees supported the conclusion of the Executive Committee that the current relationship between the Society and the Foundation is desirable and should be continued and, if supplemental funding by MSNJ becomes necessary, such funding should be made a part of the dues structure of the Society.

Filed with notation (page Tr 116)

COUNTERSIGNING OF HOUSE OFFICERS' HOSPITAL ORDERS AND TEMPORARY LIMITED LICENSURE (Reference Committee "D")

A meeting of representatives of MSNJ, the State Board of Medical Examiners, the College of Medicine and Dentistry of New Jersey, the New Jersey Hospital Association, and the Department of Higher Education was held on July 1, 1974, at the Executive Offices. The meeting was called to discuss Resolution #19 (Countersigning of House Officers' Hospital Orders) and Resolution #33 (Temporary Limited Licensure) from the 1974 House of Delegates.

Since the two resolutions dealt with the same subject matter, they were considered simultaneously. There was extensive, and at times, rather vigorous debate. Four possible solutions were discussed.

1. Requirement that all countersignatures be effected within fifteen days of discharge.

2. Requirement that all countersignatures be effected at discharge.

3. Requirement that no order by unlicensed house staff be effective unless and until approved in advance by a licensed attending or his licensed designee, except in cases of emergency.

4. Provision of a temporary limited license to house staff for the first eighteen months of their training period after which they would be expected to become regularly licensed. (Prevalent throughout the country)

Of the four proposals, the one which generated the most support was item #4. The representatives of the State Board of Medical Examiners would not, however, commit themselves to any set course of action, but did indicate they would consider taking this matter under advisement.

Filed with notation (page Tr 120)

HEALTH MANPOWER REPORT ON PHYSICIANS (Reference Committee "D")

Doctor Lewis Dars, Director, Office of Health Manpower, New Jersey Department of Higher Education, and Mr. Jon Tomson, staff, Office of Health Manpower, were present at the February meeting of the Board to discuss the recent data publication on licensed New Jersey physicians.

The document is the first in a series of health manpower information reports developed through the auspices of the Interagency Advisory Committee on Health Manpower. The Interagency Advisory Committee, a consortium composed of organizations from throughout New Jersey, has, for the last year and a half, been actively analyzing the field of health manpower. It was evident at the inception of the consortium that there was no source of uniform health manpower data in the State. Since that time, the Interagency Advisory Committee has been involved in data collection activities in an attempt to develop a uniform data set on the major Health Manpower Occupational Categories. The report presents the results of these activities as they relate to New Jersey licensed physicians (both M.D. and D.O.).

Specific results reflected in the report are: (1) availability of information to analyze the need for physician manpower by location and specialty; (2) an indication of the number of physicians actually practicing in the state; and

(3) assumption of responsibility by the Department of Health for maintaining the data system. This includes updating of information.

Another survey will be mailed with license registration renewal. Notification to MSNJ will be made prior to the mailing.

Filed (page Tr 120)

OPPOSITION TO THE OPENING OF A SCHOOL OF OSTEOPATHY IN SOUTHERN NEW JERSEY (Reference Committee "D")

On December 11, 1974, the Camden County Medical Society sent a letter to the Governor enumerating that County Society's reasons for opposing the opening of a School of Osteopathy in Southern New Jersey. Further, the Governor was requested to consider carefully all the issues listed before reaching a final decision.

A communication, also from the President of the Camden County Medical Society, was hand-delivered to the Executive Offices on December 12. Camden County requested that MSNJ support its action of opposition to a free-standing School of Osteopathy.

The Board directed that the Governor be informed that MSNJ endorses the action of the Camden County Medical Society.

The Board subsequently received a reply from the Chancellor of the Department of Higher Education in response to its communication to the Governor. The Chancellor indicated:

"You may be assured that the thinking of this Department and the College of Medicine and Dentistry of New Jersey regarding a medical educational program in southern New Jersey has always contemplated an integrated curriculum wherein the concerns of both allopathic and osteopathic medicine would be served. No free-standing osteopathic school has ever been considered, and any program launched will be conducted solely under the auspices of the College of Medicine and Dentistry of New Jersey."

Filed (page Tr 121)

CERTIFICATE OF NEED (Reference Committee "F")

The report of the Hearing Officer relevant to the September 11, 1974 Public Hearing was submitted to the Commissioner of Health and the Health Care Administration Board.

Quoting extensively from MSNJ's legal and practical arguments, the Hearing Officer questioned the legal and practical viability of the proposal. His recommendations are as follows:

a. That all those responsible for the approval and promulgation of the proposed rule consider the transcript of the hearing as well as the written communications made a part of the record thereof.

b. That a communication be addressed to the Office of the Attorney General summarizing the arguments presented at the hearing and requesting an opinion as to the legality and constitutionality of the proposed rule.

c. That, if the Attorney General's opinion is to the effect that the proposed rule is constitutional, those responsible for the promulgation of the rule should be satisfied, through documented proof, that it would further the intent of the Health Care Facilities Planning Act by providing related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized, and at a reasonable cost. No such documented proof was presented at the hearing. If after such consideration it is determined that the proposed rule is warranted and desirable, it can then be promulgated.

In order to protect MSNJ's position, the Executive Director has served notice on the Commissioner indicating that any such proof, if now supplied, would be "outside the record" and should such proof be developed, the Society be afforded an opportunity to respond thereto.

Filed (page Tr 124)

DRAFT PLANNING GUIDE FOR HOSPITAL LONG RANGE PLANS

(Reference Committee "F")

Mr. David A. Wagner, Deputy Commissioner of Health, and Mr. Charles Pierce, a member of the staff of the New Jersey Department of Health, were present at the February meeting to discuss the draft of the Planning Guide for Hospital Long Range Plans. Prior to the meeting the draft was distributed to Board members for study.

The Health Care Facilities Planning Act, Chapters 136 and 138 Laws of New Jersey, 1971 requires a health care facility in section 12a (4) of Chapter 136 to "prepare and review annually a long-range plan compatible with the State Health Plan established pursuant to . . . Federal Law 89-749." The authority of the State to require these plans and that they be shared with other agencies is derived from this State law.

There are two primary purposes for the State of New Jersey to require the development of long-range plans by health care institutions. The first is to encourage hospitals to use a proven management process to analyze their present and future role in the health care system in their area. Second is to promote and improve areawide health planning.

The intention of the State of New Jersey is to encourage a useful and relatively coherent planning process in all health care institutions. One year after publication of the regulations for planning each health care institution must submit two copies of its plan. One copy will stay with the Department of Health and the other will be sent to the appropriate areawide planning agency.

The State will certify a plan to indicate only that it meets the regulations. An incomplete plan will be returned to the institution with the deficiencies noted. State certification does not mean or imply approval of the institution's future intentions or expectations that are described in the plan.

A brief question and answer period followed general discussion of the draft. When the draft is finalized, the Board will be afforded another opportunity to review and comment.

Filed (page Tr 124)

FEDERAL CATASTROPHIC HEALTH INSURANCE (Reference Committee "F")

The 1974 House of Delegates adopted Resolution #9 (Federal Catastrophic Health Insurance), and the Board subsequently referred the resolution to the AMA Delegation.

This resolution was combined with AMA Resolution #47 (A-74), sponsored by the California Delegation and subsequently amended. The final adopted "resolved" reads as follows:

That the AMA Board of Trustees immediately, in concert with state associations, attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will insure the provision of health in-

surance coverage through the purchase of private health insurance; and seek means to secure favorable Congressional and public support for their adoption.

Filed (page Tr 124)

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

(Reference Committee "F")

On March 5, the President, Chairman of Board, and Executive Director attended a meeting called by the Commissioner of Health to discuss the National Health Planning and Resources Development Act of 1974 (P.L. 93-641).

This new federal legislation requires the Governor to recommend to the Secretary of Health, Education, and Welfare, the boundaries of health service areas within the state. The agencies ultimately developed within these areas will have a major impact on health planning and the disbursement of federal project funds in future years.

In a communication to the Commissioner of Health, the Board indicated that the Society does not believe that the interests of the people of New Jersey or those of the surrounding states will be well served by alignment of several New Jersey counties with peripheral states. Such a plan defies economic, administrative, and service delivery factors. New Jersey, therefore, must be designated as a unit planning area.

Insofar as the health service areas themselves, MSNJ believes the most orderly and rational approach would be to follow PSRO area designations.

Filed (page Tr 124)

AD HOC COMMITTEE TO FORMULATE GUIDELINES FOR THE UNIFORM PROCUREMENT OF BLOOD

(Reference Committee "G")

At its July 21, 1974 meeting, the Board of Trustees authorized the creation of an Ad Hoc Committee to study and formulate guidelines for the uniform procurement and supply of blood in New Jersey.

This committee has issued two Statewide questionnaires, without cosponsorship of the

agencies currently responsible for supplying the blood needs of the State. Impressed with the complexities and the entrenched parochialism of the current system, the Committee continues to evaluate alternatives to the present competitive and fragmented system. Clearly the goal is a reliable supply of volunteer blood at predictable cost, and the Committee's efforts are so directed. Further meetings are scheduled, and it is anticipated a full report with concrete recommendations will soon be made to the Board for its consideration.

Filed (page Tr 126)

ANNUAL REPORTS

(Reference Committee "H")

Traditionally, each and every Council and Committee of this Society prepares an annual report for submission to the House of Delegates. Most of these reports are merely historical narratives and are rarely, if ever, carefully read by Society members.

It is the Board's belief that the function of the House and the interests of the members would be better served by spending more time on consideration of resolutions and specific reports rather than the present format. Additionally, printing and preparation costs could be substantially reduced.

Only those reports required by the Constitution and Bylaws, those requesting action of the House, and those requested by the House for report back would be distributed for consideration at annual meetings. A copy of those annual reports not being presented to the House would be available for perusal. This action would not become effective until the 1976 Annual Meeting.

A resolution from the Board will be presented to the 1975 House of Delegates for consideration.

Filed (page Tr 128)

MEMBERS OF THE PRESS ATTENDING SESSIONS OF THE HOUSE OF DELEGATES

(Reference Committee "H")

At its meeting on June 13, 1974, the Standing Committee on Annual Meeting recommended to the Board of Trustees that beginning in 1975,

members of the press, displaying official badges, be admitted to the sessions of MSNJ's House of Delegates.

This recommendation was referred to the Council on Public Relations for consideration and report. The Council, after careful discussion, voted unanimously in favor of members of the press, displaying official badges, being admitted to the House of Delegates.

The Board was in favor of the proposal and directed that it be referred to the House of Delegates for concurrence at the opening session.

Filed (page Tr 128)

REFERENCE COMMITTEE MEMBERS (Reference Committee "H")

During the 1974 Annual Meeting, the Board noted that there were four reference committees that had members unable to attend. In order to permit the delegates to have the benefit of the thinking of a five-member committee, the Board directed that each reference committee shall have one alternate member appointed who will be eligible to participate in the deliberations of the committee, but will not be permitted to vote unless a regular member is not in attendance. This recommendation will be implemented during the 1975 Annual Meeting.

Filed (page Tr 128)

Supplemental Report

As the result of its April 20 meeting, the Board of Trustees directed that the following item be brought to the attention of the 1975 House of Delegates. The Board, therefore, submits this supplemental report, which has been compiled since the preparation of its annual report.

MEDICAL-SURGICAL PLAN BOARD OF TRUSTEES (Reference Committee "C")

Medical-Surgical Plan of New Jersey has submitted the following nominees for terms on the Board of Trustees of Medical-Surgical Plan of New Jersey, as indicated:

Three-year term (1975-1978):

Name	Type of Practice	Member of Component Society
Donald T. Akey, M.D.	Surgeon	Middlesex
Robert G. Boyd	Businessman	—
Joseph A. Cox, M.D.	Anesthesiologist	Essex
Frederick L. Hipp, Ed.D.	Exec. Vice-Pres. (NJEA)	—
Josephine B. Janifer	Social Worker	—
William M. Mortenson	Businessman	—
James A. Rogers, M.D.	Internist	Passaic
Sidney I. Simon, Ph.D.	College Professor	—
Morgan Sweeney	Businessman	—
Robert E. Verdon, M.D.	General Practitioner	Bergen

Two-year term (1975-1977):

Charles I. Nadel, M.D.	Orthopedic Surgeon	Essex
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One-year term (1975-1976):

Leonard D. Koch	Businessman	—
Kevin J. Coakley, Esq.	Attorney	—

The following named persons will continue membership on the Board of Trustees until the expiration of their terms in the year indicated — or until their successors are elected and qualified:

Terms expiring 1976:

Name	Type of Practice	Member of Component Society
A. Guy Campo, M.D.	General Practitioner	Gloucester
Edgar P. Eaton, Jr.	Businessman	—
Mortimer J. Fox, Jr.	Retired Businessman	—
Walter H. Miller, D.O.	Osteopath	—
Henry J. Mineur, M.D.	Internist	Union
John R. Nevin	College Administrator	—
Ronald K. Seywert	Businessman	—
John F. Waters	Labor Leader	—
Edwin H. Albano, M.D.	Pathologist	Essex
William M. Chase, M.D.	Internist	Essex
Lloyd M. Felmly	Retired Newspaper Editor	—
John Kelley	Retired Labor Leader	—
Samuel J. Lloyd, M.D.	Medical Consultant	Mercer
Theron L. Marsh	Banker	—
Zelda J. Paulsen	Businesswoman	—
Rudolph C. Schretzmann, M.D.	Obstetrician/Gynecologist	Bergen
Charles O. Tyler, M.D.	Pediatrician	Camden

Not included in the preceding list of members serving on the Board of Trustees are the Chairman of the Board of Trustees of Hospital Service Plan of New Jersey and the President of The Medical Society of New Jersey, each of whom serve during their respective terms of office in those organizations.

Approved (page Tr 118)

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton

(Reference Committee "A")

The Judicial Council has maintained its schedule of regular monthly meetings. From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from May 12, 1974 through March 23, 1975.

BY JUDICIAL COMMITTEES

Complaints reported as disposed of49

Alleging:

Dissatisfaction concerning fees21
Unprofessional conduct14
Dissatisfaction concerning medical procedures7
Dissatisfaction concerning professional ethics7

BY THE JUDICIAL COUNCIL

Meetings held6
Official communications acted upon35
Appeal hearings requested10
Appeal hearings granted10
Formal opinions rendered0
Policy Statement Issued:
Conflict of Interest — Officers and Trustees of The Medical Society of New Jersey (Exhibit A)

1974 Formal Opinion Revised:

Ethicality of an ophthalmologist employing in his office an optician to sell or dispense glasses or contact lenses whereupon a portion of the profits would inure to the benefit of the physician in question (Exhibit B)

The foregoing opinion and statement are presented in full as an appendix to this report.

JUDICIAL WORKSHOP FOR CHAIRMEN, EXECUTIVE SECRETARIES, AND MEMBERS OF JUDICIAL COMMITTEES OF COMPONENT SOCIETIES

In January, the Council held a Judicial Workshop for the chairmen, executive secretaries, and members of the Judicial Committees of component societies. This meeting was held in order to reacquaint those dealing with the judicial mechanism with the Rules and Regulations for the processing of grievances and complaints involving members of The Medical Society of New Jersey and its component

medical societies. The revised "Regulations" were distributed and discussed.

Fee adjudication seems to be of great concern. The physician-chairmen, members of the judicial committees, and the executive secretaries feel that there should be some sort of guideline available as to the determination of reasonable fees. The Council pointed out that these problems can be readily solved by consulting the California Relative Value Scale, the MSP of New Jersey, the Prudential Insurance Company, or specific specialists in the area.

Third party complaints seem to be the most prevalent. In one particular county they have established a sub-committee of the judicial committee whose members consist of a representative from each specialty group. Complaints concerning fees are sent to this committee for a fee comparison of physicians in that area. This particular county advises that the third party carriers, in most cases, accept the sub-committee's disposition.

It was recommended by the Judicial Council that this sub-committee should not render any decisions, they should only make recommendations, the final disposition should come from the judicial committee. The Council advised that the judicial mechanism calls for complete confidentiality and the privacy of the mechanism was stressed. It was also advised that fees should be discussed in advance and the patient should be advised whether or not the physician is a participating member of MSP.

Store-front clinics are presenting quite a problem in many northern counties with physicians from other counties operating them on a 9 to 5 basis and after 5 leaving any seriously ill patient or emergency case to the doctors or hospitals in the area. These complaints should be processed through the appropriate legal authorities such as the Division of Consumer Affairs or the Department of the Public Advocate.

The Council was requested to advise as to the length of time the records of the judicial committees should be retained, and is of the opinion that all original materials be held until the final disposition is made. If the complaint has been reported to the Judicial Council, report forms A and B should be retained for ten years. All other materials may be destroyed or returned to the parties.

There was quite a discussion on public censure and it was the consensus of the Council that an official statement be issued on the definitions and penalties for public censure, private censure, expulsion, and suspension.

Private Censure — involves the verbal disciplining of a member by the judicial committee in executive session. A report thereof should be forwarded to the Judicial Council.

Public Censure — would be invoked in more serious cases. It would consist of censure of the affected member before a meeting of the county medical society.

Suspension — should be utilized for very serious offenses and for members who have failed to correct patterns of abuse. A suspension should be for a stated and definite time.

Expulsion — is to be utilized in only the gravest of situations. Judicial committees should exercise this option with caution or after other less stringent measures have failed.

All judicial committees are advised to hold actions of public censure, suspension, or expulsion in abeyance until such time as the 45-day appeal period has expired and an appeal has not been perfected.

It is understood, of course, that any time the New Jersey license of a member is suspended or revoked, the component society will immediately terminate membership.

The purpose of this workshop was to achieve a better understanding of, and increased efficiency in, the operation of the Society's statewide judicial mechanism. There were 33 in attendance at this meeting and 14 counties were represented.

ADHERENCE TO REGULATIONS

The Council pointed out to the chairmen of the judicial committees of the component societies that there continues to be some inadequacy of cooperation with the Judicial Council on the part of the committees. One of the main

problems is failure to file, or lateness in filing, the required report forms to inform the Council of the existence and status of complaints before county judicial committees. Many times the Council has received requests for appeal hearings concerning complaints disposed of, but not reported, by county judicial committees.

In other instances, investigation has disclosed that some county judicial committees disregard the requirement that all principals be invited to be present and to participate in the hearings that are mandated whenever an amicable settlement proves impossible of accomplishment.

The Council urges that each county judicial committee strive to improve its procedures in these regards. Therefore, the committees are again reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints*. Only by means of a full understanding and observance of the "Regulations" can the judicial committees together with the Judicial Council succeed in functioning at the level of adequacy intended by MSNJ's House of Delegates.

Exhibit A

CONFLICT OF INTEREST — OFFICERS AND TRUSTEES OF THE MEDICAL SOCIETY OF NEW JERSEY

The Judicial Council has been requested to develop a policy statement concerning what constitutes a conflict of interest for officers and trustees of the Society who are employed by third party organizations or are serving in governmental capacities.

The Council believes that officers and trustees must exercise intellectual and practical honesty and be capable of rendering unequivocal decisions on behalf of the welfare of the membership of The Medical Society of New Jersey. They must be prepared to pursue MSNJ goals and established policy with the clearest conscience. Their actions when dispassionately, objectively, and critically viewed must exemplify integrity and fairness to the membership of The Medical Society of New Jersey.

Obviously, employment by third parties or governmental agencies may well compromise the ability of officers and trustees employed by such groups or organizations to function in accordance with the aforementioned criteria.

Officers and trustees who find themselves subject to conflicting loyalties may tend to abstain on issues in which they might be subject to the charge of "conflict of interest." The decision not to vote on such a measure is tantamount to an admission of inability to act unequivocally on behalf of the medical profession and is not to be condoned. Therefore, officers and trustees who find themselves subject to conflicting loyalties should resign from one or the other position in order to avoid equivocation.

The Nominating Committee must carefully scrutinize all candidates for office and screen out those whose positions could present potential for conflict.

The Judicial Council has deliberated long and arduously over the question presented. Patently, the statement that has evolved from our study must be judiciously applied to the individual characteristics of the candidates for the various offices within The Medical Society of New Jersey and that obligation, for the most part, rests with the Nominating Committee and the House of Delegates.

Exhibit B

ETHICALITY OF AN OPHTHALMOLOGIST EMPLOYING IN HIS OFFICE AN OPTICIAN TO SELL OR DISPENSE GLASSES OR CONTACT LENSES WHEREUPON A PORTION OF THE PROFITS WOULD INURE TO THE BENEFIT OF THE PHYSICIAN IN QUESTION

This question presents a complicated issue in which each case must be carefully evaluated according to its own circumstances. Since the Council has been requested to answer a specifically pointed issue it will do so. However, certain general rules must first be established and understood. They are as follows:

(1) That the patient's best interest and welfare are the primary concern of the physician.

(2) That, when the ophthalmologist determines the best interests of his patients require that glasses and lenses be provided, the patient must still be given free choice of optician and no undue influence may be exercised upon him.

(3) There are indeed and will continue to be instances where sound and ethical practice will dictate that the ophthalmologist supply glasses and contact lenses to his patients. In those instances it is to be expected that the ophthalmologist is entitled to charge for the costs incurred in providing such a service including a reasonable factor for breakage and wastage.

The philosophy of the AMA in this regard is contained in Opinion #47 appearing under Section 7 of the *Principles of Medical Ethics*.

"Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient." Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine.

It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done.

On the other hand, this broad language provides a means by which a component society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the best exercise of sound discretion may dispense "in the best interest of his patient;" it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.

Since in the question presented, it is stated that the physician will profit from the services of the optician, the Council finds the practice not in the best interest of the patient, but a plan to supplement the income of the physician and therefore, declares such practice in this instance to be unethical.

Filed (page Tr 115)

Executive Director

Vincent A. Maressa, Trenton

(Reference Committee "A")

"I am not really concerned about the physicians, sure they have a problem but they make plenty of money as well" — so stated the Commissioner of Insurance on November 5, 1974. Three months later A-1552 was introduced and the issue was joined. At various times during a public hearing on this bill the Commissioner stated that the bill — "would not reduce the cost of insurance" — "would reduce the cost of insurance" — "may increase the cost of insurance." Meanwhile, at this same public hearing his chief actuary maintained that the bill was desirable and admitted at the same time that it would not "reduce" premiums or "control" increases. This bill, in case you haven't heard, is the proposed answer to your malpractice insurance problems. Its main thrust is the creation of a State controlled and managed reinsurance facility which would be funded through your premiums. Your Society opposed this arrangement as being a financial disaster in the malpractice insurance field.

The following statement by the former Federal Insurance Administrator and First Deputy of Insurance in New York State (who developed this concept for other lines of insurance) concerning this bill typifies the argument against it and is worthy of repetition here:

"Unfortunately, any pride I might feel in witnessing my proposal introduced in legislative form in this State is dissipated by the knowledge that the reinsurance facility proposal is being applied to a line of insurance where it is totally inappropriate. The reinsurance facility concept will not and cannot work in medical malpractice insurance."

Meanwhile, the Department of Health initiated one of the most massive assaults against the private practice of medicine yet witnessed in the United States when it proposed the controversial redefinition of "Certificate of Need." The Commissioner's philosophy in this regard is probably most concisely represented in the statement that there is "no need to have a practicing physician serve on the Health Care Administration Board."

Since this topic and many others of equal interest are covered more thoroughly elsewhere, I will not impose on your tolerance by discussing them here at any greater length.

Suffice it to say that this past year has been interesting, exciting, pressure packed, and chaotic. Your Society has established itself as a true advocate of the profession and looks forward to effectively expanding that role in the upcoming years.

Filed (page Tr 115)



MSNJ President Rogers, AMA President Todd, MSNJ President-Elect McGuire

Standing Committees

Annual Meeting

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "H")

This year for the first time since any of us cares to remember or can for that matter recall, the Annual Meeting of The Medical Society of New Jersey will be held somewhere other than the Haddon Hall Hotel in Atlantic City. This decision was not lightly made. Your Committee Chairman, the President of MSNJ, and members of the staff met with officials of the hotel. They were inflexible in regard to dates offering us Mother's Day weekend, Memorial Day weekend, or early April. They would not provide a separate registration area, extra garagemen, or traffic control and refused any discussion as to convention rates on rooms. The Committee and the Board of Trustees therefore responded accordingly.

Your Committee has labored long and hard in arranging this year's program at the Garden State Convention Center. We have done our best to anticipate the logistical and tactical problems that are necessarily involved in a multi-facility meeting. The cooperation of the Cherry Hill Convention Bureau in this regard has been outstanding.

This year's program should prove challenging and interesting to all members with the scientific sessions and exhibits being of unparalleled quality. Additionally, top flight entertainment will be available at the social functions. The "First Annual Governor's Conference on Unresolved Questions Affecting the Delivery of Health Care" will be held on Saturday, May 31 at 8:30 a.m. at the Garden State Convention Center and will feature nationally known experts.

I will not recount for you the daily schedule of events since the Advance Program was mailed in February to the entire membership and the April issue of *The Journal* carried detailed information including abstracts of scientific presentations, exhibit descriptions, and room assignments.

In regard to the 1976 Annual Meeting the following recommendation is submitted:

Recommendation

That the Committee on Annual Meeting be authorized to select the date and location of the 1976 Annual Meeting subject to the approval of the Board of Trustees.

Approved (page Tr 128)

Filed (page Tr 128)

SCIENTIFIC EXHIBITS

Francis X. Keeley, M.D., Chairman, Haddonfield

This year, rather than poll Committee members by mail, an organizational meeting was held in September, 1974 and then a final meeting in February, 1975.

Applications for the 1975 Scientific Exhibits were widely distributed throughout the State of New Jersey and also to major institutions and interested exhibitors in Delaware, Maryland, eastern Pennsylvania, and southeastern New York.

Because of a change in the location of the convention, a new floor plan outlining the location of the scientific and informational exhibits was approved with the assistance of Mrs. Walton, Convention Manager. The number of requests for scientific and informational exhibits almost doubled from the previous years and additional space had to be allocated. Several interesting and worthwhile exhibits had to be rejected because of lack of space or late applications. Applicants for the 1976 meeting are urged to apply early to avoid this problem.

At the February meeting, the Committee reviewed and approved applications for space and the final floor plans. An attempt was made to cluster exhibits by interest in specialties, rather than medical/surgical separations alone.

We hope the new format will engender increased interest. The previous cost policy of \$150 per 10 feet occupied by informational exhibits was continued.

The Committee agreed that there would be first and second place award plaques for New Jersey exhibitors and first and second place award plaques for out-of-state exhibitors. A special award plaque to be awarded by the Committee on Scientific Exhibits for overall excellence will be given this year, and up to 10 Honorable Mention Certificates for the scientific exhibits are to be awarded. It was also recommended that all scientific exhibitors receive Certificates of Merit.

The Committee directed that the President be requested to appoint a committee of five to act as the committee on awards to judge the scientific exhibits, and that the committee members be drawn from the various specialties. The awards will be presented on Monday morning and an announcement made Monday afternoon at the House of Delegate.

Film brochures were reviewed by the chairman and 19 films were selected for showing at the motion picture theater during five two-hour sessions, from Saturday afternoon through Monday afternoon. Once again, an attempt was made to cluster the topics so that each session would attract an audience with the same general interest.

Filed (page Tr 128)

SCIENTIFIC PROGRAM

Arthur Bernstein, M.D., Chairman, Maplewood

The Officers of the 1975 Scientific Sections met in September with the Committee on Annual Meeting and representatives of the New Jersey specialty societies and the Academy of Medicine of New Jersey.

The Committee reviewed the attendance at and expenses incurred in presenting the 1974 Scientific Sessions, and urged that all Section Officers utilize, as far as possible, the excellent medical talent which is available in our State now that New Jersey boasts two medical schools.

All scientific sections will meet in 1975, with the exception of the Section on Obstetrics and Gynecology. The New Jersey Obstetrical and Gynecological Society expects to hold a business meeting in conjunction with our Annual Meeting.

At the 1975 Annual Meeting, 34 member-speakers and 28 guest-speakers will present scientific papers at 17 scientific sessions. In addition, the Annual Spencer T. Snedecor Trauma Oration will feature an outstanding guest-speaker and the New Jersey Chapter, American College of Chest Physicians, will again sponsor the Annual Selman A. Waksman Lecture.

The policies governing scientific sessions were reviewed and it was recommended that the honoraria to be presented to guest-speakers be increased from \$100 to \$150. The Board approved the recommendation.

Again this year, all of the scientific sessions will be co-sponsored by one or more of the New Jersey specialty societies. This practice has greatly increased attendance at the sessions in the past several years.

As was instituted last year, your Committee is pleased to announce that, through the Academy of Medicine of New Jersey, hour-for-hour credit for all of the 1975 scientific sessions has been approved for Category I, AMA Physicians Recognition Award, Continuing Medical Education Program, MSNJ; the three sessions being sponsored by MSNJ's Section on Family Practice have been approved for two hours of prescribed credits by the American Academy of Family Physicians.

All exhibits, meetings of the House of Delegates, and scientific sessions will be held in the Garden State Park Convention Center, Cherry Hill. The scientific sessions will be held on Sunday and Monday, June 1 and 2. The following schedule has been set up for the 1975 scientific sessions:

Sunday, June 1 — a.m.

Session on Emergency Medicine — co-sponsored by New Jersey Chapter, American College of Emergency Physicians

Joint Session on Allergy, Otolaryngology — co-sponsored by New Jersey Allergy Society and New Jersey Academy of Ophthalmology and Otolaryngology

Joint Session on Cardiovascular Diseases, Family Practice, Medicine — co-sponsored by New Jersey Academy of Family Physicians and New Jersey Society of Internal Medicine

Session on Pediatrics — co-sponsored by New Jersey Chapter, American Academy of Pediatrics

Joint Session on Radiology, Urology — co-sponsored by New Jersey Chapter, American College of Radiology

Sunday, June 1 — p.m.

Joint Session on Anesthesiology, Medicine — co-sponsored by New Jersey State Society of Anesthesiologists and Academy of Medicine of New Jersey

Joint Session on Clinical Pathology, Rheumatism — co-sponsored by New Jersey Society of Pathologists and New Jersey Rheumatism Association

Session on Family Practice — co-sponsored by New Jersey Academy of Family Physicians

Joint Session on Neurosurgery and Neurology, Plastic and Reconstructive Surgery — co-sponsored by New Jersey Neurosurgical Society, Neurological Association of New Jersey, and New Jersey Society of Plastic and Reconstructive Surgeons

Session on Ophthalmology — co-sponsored by New Jersey Academy of Ophthalmology and Otolaryngology

Session on Psychiatry — co-sponsored by New Jersey Psychiatric Association

Monday, June 2 — a.m.

Session on Surgery — co-sponsored by New Jersey Chapter, American College of Surgeons, College of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, and College of Medicine and Dentistry of New Jersey-Rutgers Medical School, Piscataway

Session on Dermatology — co-sponsored by New Jersey Dermatologic Society

Session on Orthopedic Surgery — co-sponsored by New Jersey Orthopaedic Society

Joint Session on Chest Diseases, Family Practice, Medicine — co-sponsored by New Jersey Chapter, American College of Chest Physicians, New Jersey Academy of Family Physicians, and New Jersey Society of Internal Medicine

Monday, June 2 — p.m.

Session on Gastroenterology and Proctology — co-sponsored by New Jersey Gastroenterological Society

Session on Physical Medicine and Rehabilitation — co-sponsored by New Jersey Society of Physical Medicine and Rehabilitation

The following luncheon/meetings have been scheduled in conjunction with the 1975 Scientific Sessions:

Executive Council Meeting — New Jersey Chapter, American Academy of Pediatrics; followed by a cocktail reception and dinner

New Jersey Chapter, American College of Emergency Physicians

New Jersey Allergy Society

New Jersey State Society of Anesthesiologists

New Jersey Academy of Ophthalmology and Otolaryngology

New Jersey Dermatologic Society

New Jersey Orthopaedic Society

New Jersey Chapter, American College of Chest Physicians

Filed (page Tr 128)



President Rogers receives Fellow's Key from Immediate Past-President Boylan



and Mrs. James Brennan, President of the Woman's Auxiliary, receives Fellowette's Pin from Dr. Rogers.

Credentials

Charles L. Cunniff, M.D., Chairman, Jersey City

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This

procedure will help insure more accurate and speedy evaluation of credentials.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1974 to February 28, 1975.

	<i>*Associate</i>	<i>Active</i>	<i>Total</i>
Received	1	829	830
Reviewed and found:			
Satisfactory	1	774	775
Unsatisfactory	0	0	0
Pending	0	55	55
Total	1	829	830

*Associate Resident (non-licensed in New Jersey)

Filed (page Tr 115)



MSNJ Staff and Guests — Mr. Sullivan, Mrs. Lucci, Mr. Lucci, Mrs. Chrismer, Mr. Squireck, Mrs. Hamer, Mrs. O'Hare, Mr. Crane — Mr. Smith in the foreground

Honorary Membership

Charles H. Calvin, M.D., Chairman, Edison

(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were

held during this administrative year.

Filed (page to 128)

Finance and Budget

David Eckstein, M.D., Chairman, Trenton

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative (fiscal) year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

THE JOURNAL AND ANNUAL MEETING EXPENSE

The (net) *Journal* Deficit is anticipated to be higher, even though this will be the third year that a per capita assessment designated for each member's *Journal* subscription rate will be applied. The dues allocation to the *Journal* will be \$5 per member for 1975 as it was for 1974 or one half of the yearly subscription rate.

The anticipated increase in the net deficit can be attributed to several factors: (1) Continued reduced volume of national advertising supplied by SMJAB; however, effective June 1, 1975 *The Journal* will no longer be associated with SMJAB (State Medical Journal Advertising Bureau). All national advertising revenue will be generated through United Media Associates, an advertising firm located in New York. (2) An increase in costs, both publication and non-printing costs, centering on personnel salaries, taxes, commissions, office expenses and insurance; however, effective January 1, 1975 a new printer (Dartmouth Printing) was engaged to print our monthly publication at 14% less in production cost for the calendar year 1975. (3) The effects of the new rate structure covering increases for full and for one-half page advertisements, did not yield the anticipated impact because of reduced advertising space sales. The experience in 1975 has been consistent for all state journals, the group associated with as well as not associated with SMJAB. However, with the changes noted above, it is felt that the end results will be favorable to *The Journal*.

Your Committee recommended, with the concurrence of the Board of Trustees, that the 1976 assessment include a \$5 and \$2.50 per capita assessment designated for each member's *Journal* subscription rate, and Annual Meeting registration rate, that the full amount realized as

of May 31, 1976 be applied in 1976, and that the Committee on Finance and Budget be called upon to review these allocations annually.

Your Committee was cognizant of the fact that the above action will not completely discharge the deficits incurred each year in these two accounts. Nevertheless, the net deficit in each account will be considerably less and will readily be charged to the unexpended balance of the fiscal budget.

AMERICAN MEDICAL COMPUTER ASSISTANCE PROGRAMS

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$24,000 in the budget for participation in AM-CAP. The computer programs will provide an automated system that will not only benefit MSNJ but also the Component Societies and the Academy of Medicine of New Jersey.

MEDICAL EDUCATION AND THE ACADEMY OF MEDICINE OF NEW JERSEY

Your Committee again has approved, with the concurrence of the Board of Trustees, the inclusion of \$25,000.00 in the budget of the Committee on Medical Education for 1975-76 for the Academy of Medicine of New Jersey for post-graduate educational programs and activities, with the proviso that the Committee on Medical Education, with the concurrence of the Board of Trustees, be empowered to expend up to this amount in the course of the administrative (fiscal) year on the basis of need reflected in the 1975-76 fiscal report to be submitted by the Academy of Medicine to the Committee on Finance and Budget.

EMERGENCY MEDICAL CARE AND THE INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$10,000 in the budget of the Committee on Emergency Medical Care for 1975-76 for the

Inter-Agency Commission on Emergency Medical Care. The foregoing represents a net increase of \$2,500, because the Committee on Emergency Medical Care does not anticipate expending the \$7,500 budgeted in 1974-75.

LITIGATION FUND

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$10,000 in the budget of the Legal Account. This represents a transfer of \$2,000 from the Council on Public Relations and \$8,000 added to it to establish this accumulative fund.

PHYSICIANS' RELIEF FUND

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$6,000 establishing a new account for 1975-76 for the Physicians' Relief Fund. The monies allocated will be used to replenish the expenditures experienced during the 1975-76 fiscal year.

NEW JERSEY FOUNDATION FOR HEALTH CARE EVALUATION

Your Committee has approved, with the concurrence of the Board of Trustees, the proposed 1975-76 Budget prepared by the Finance Committee of the New Jersey Foundation for Health Care Evaluation. Although the budget totals \$155,647, it will not be necessary for MSNJ to fund NJFHCE for 1975-76. However, it might be required in the future as a budget line item.

1976 ASSESSMENT

The computation of unappropriated General Fund balance at the close of the current fiscal year is estimated at \$242,320.26 — 21.2% above the \$200,000.00 sum approved, with the concurrence of the Board of Trustees, as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1975 and 1976 per capita assessment to the

1975-76 fiscal year on the basis of 7/12 of the 1975 assessment for the new fiscal year soon to commence (June 1, 1975) and 5/12 of the 1976 assessment for the latter part of that fiscal year starting January 1, 1976.

The following is the Computation of the Cash Surplus and the Determination of the 1976 Assessment: (Unappropriated General Fund Balance)

Proposed budget for 1975-76	\$734,412.00
7/12 of 1975 assessment applicable to 1975-76 budget	\$353,643.00

Amount to be raised by 5/12 of 1976 assessment	\$380,769.00
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\$121.27 × 7,536 members paid = \$913,890.72	
× 5/12	\$380,787.80

Amount to be raised with surplus over \$200,000 applied to budget excess at 5/31/75, estimated	\$ 42,320.26
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Amount needed to reduce the per capita assessment from \$121.27 to \$110	\$ 35,369.00
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Remainder of surplus in excess of \$200,000.00	\$ 6,951.26
Add the required surplus	\$200,000.00

Estimated adjusted cash surplus at 5/31/75	\$206,951.26
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\$110 × 7,536 members paid = \$828,960	
× 5/12	\$345,400.00
plus the amount raised from surplus	\$ 35,369.00

Amount to be raised to meet 5/12 requirement	380,769.00
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FOR EACH \$1,000 increase in the proposed budget add .318¢ to assessment.

FOR EACH \$1,000 decrease in the proposed budget subtract .318¢ from assessment.

1975-76 BUDGET

The proposed budget for 1975-76 totals \$734,412. It is the opinion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, your Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Recommendations

(1) That the budget for 1975-76 be adopted in the total sum of \$734,412.00.

Approved (page Tr 117)

(2) That the 1976 assessment be adopted at \$110.00 per capita, with no provision for a contribution to AMA-ERF. The dues' assessment will cover a budget allocation, for the seventh consecutive year, to the Academy of Medicine of New Jersey which eliminates the need for a special assessment therefor. The dues' assessment will also cover a budget allocation, for the second year, to the Inter-Agency Commission on Emergency Medical Care. Of the \$110.00 per

capita assessment, \$5.00 and \$2.50 be designated respectively for the member's *Journal* subscription and Annual Meeting registration; and that the full amounts realized as of May 31, 1976, be applied in 1976.

Approved (page Tr 117)

(3) That the 1976 assessment be set at \$20.00 per capita for affiliate and associate members as it was for 1975.

Approved (page Tr 117)

Filed with commendation to the chairman and his committee.
(page Tr 117)

Account	Current Budget 1974-75	Footnotes	Proposed Budget 1975-76
A— 1—Executive Salaries	\$ 98,485.50	(1)	\$113,097.00
A— 2—General Staff Salaries	192,882.75	(1)	234,255.33
A— 3—Gen. Exec. Office Expenses	27,000.00	(2)	32,000.00
A— 4—Executive Travel	4,700.00	(3)	7,600.00
A— 5—House Maintenance	30,500.00	(4)	34,400.00
A— 6—Treasurer	8,400.00	(5)	9,900.00
A— 7—Finance & Budget	75.00		75.00
A— 8—Secretary	400.00		400.00
A— 9—Salary Taxes	17,128.75	(1)	20,034.67
A—10—Insurance	14,000.00	(6)	18,500.00
A—11—House Reserve	10,000.00		9,200.00
A—12—MSNJ Pension Plan	2,200.00	(7)	4,200.00
A—13—MSNJ Building Loan	14,100.00		12,800.00
A—14—AM—CAP Computer Programs		(8)	24,000.00
C— 2—Legislation	8,500.00		7,000.00
C— 3—Public Health	3,300.00	(9)	5,400.00
C— 4—Public Relations	37,000.00		35,300.00
C— 5—Medical Services	750.00		750.00
C— 6—Mental Health	1,700.00		1,700.00
D— 1—President-Pres. Officers	16,300.00	(10)	17,800.00
D— 2—AMA Delegates	19,320.00	(10)	24,400.00
D— 3—Woman's Auxiliary	6,680.00		6,300.00
D— 4—Medical Education	30,500.00	(11)	30,500.00
D— 5—Conference Groups	500.00		500.00
D— 6—Membership Directory	21,600.00		20,000.00
D— 7—Emergency Medical Care	7,900.00	(12)	10,400.00
D— 8—Credentials	1,200.00		1,200.00
D— 9—Archives & History		(13)	1,000.00
D—11—Med. Def. & Insurance	700.00		700.00
D—12—Mem. Inq. & Complaint	1,000.00		1,000.00
E— 1—Board of Trustees	8,500.00	(14)	9,000.00
E— 2—Contingent	10,000.00		10,000.00
E— 3—Judicial Council	500.00	(14)	1,000.00
E— 4—Legal	3,550.00	(15)	13,000.00
E— 6—Medical Student Loan Fund	6,000.00		6,000.00
E— 7—Authorized Reimbursement for Representatives to Meetings	4,500.00		5,000.00
E— 8—Physicians' Relief Fund		(16)	6,000.00
TOTALS	\$609,872.00		\$734,412.00

- (1) Increase due to increments granted to both executive and general personnel.
- (2) Increased to cover higher luncheon cost and preventive maintenance agreements charged to this account.
- (3) Increased to cover the purchase of new executive car.
- (4) Increased to cover higher utility and house maintenance costs.
- (5) Increased to cover higher expenses anticipated in bookkeeping and accounting services.
- (6) Increased to cover higher expenses anticipated under the insurance programs for the staff and the Executive Offices of The Medical Society of New Jersey.
- (7) Increased to cover anticipated expenses in revising MSNJ Employees' Pension Plan to comply with the Pension Act signed into law, September, 1974.
- (8) Establishes a new account covering anticipated expenses associated with participation in the American Medical Computer Assistance Programs.
- (9) Increased to cover anticipated expenses associated with a cosponsored AMA seminar.
- (10) Increased to cover higher anticipated expenses in attendance at the AMA Annual and Clinical Conventions.
- (11) The Medical Education Committee, with the concurrence of the Board of Trustees, is empowered to expend up to \$25,000.00 in the course of the administrative year (1975-76) to the Academy of Medicine of New Jersey for postgraduate educational programs and activities, on the basis of need reflected in the fiscal report to be submitted by the Academy to the Committee on Finance and Budget.
- (12) Increased to cover the inclusion in the budget of the Committee on Emergency Medical Care for 1975-76, \$10,000.00 earmarked for the Inter-Agency Commission on Emergency Medical Care.
- (13) This account has been reactivated to serve the Committee on National Bicentennial Celebration for production of an exhibit on the history of medicine in New Jersey.
- (14) Increased to cover higher expenses anticipated in these accounts.
- (15) Increased to cover the establishment of a "Litigation Fund" in this account. The unexpended portion of the fund will be allowed to accumulate.
- (16) This account has been established to replenish the expenditures experienced during fiscal years 1974-75 and 1975-76.

STATE SOCIETIES DUES FOR THE YEAR 1975

Below are the fifty-one State Societies in the order from the highest dues assessment down to the lowest:

1. Nevada	\$260	26. Maine	\$125
2. Alaska	250	27. Alabama	125
3. District of Columbia	220	28. Ohio	125
4. Idaho	210	29. Arkansas	125
5. Hawaii	205	30. Kansas	125
6. Montana	200	31. Mississippi	125
7. Iowa	200	32. Washington	122
8. South Carolina	180	33. New Hampshire	120
9. South Dakota	175	34. Oklahoma	120
10. Wisconsin	175	35. Indiana	110
11. Wyoming	175	1976* 36. Maryland	100
12. Utah	165	37. New York	100
13. Oregon	155	38. Georgia	100
14. Michigan	155	39. Nebraska	100
15. Colorado	150	40. Pennsylvania	100
16. North Dakota	150	41. Rhode Island	100
17. West Virginia	150	42. Vermont	100
18. Delaware	140	1975* 43. New Jersey	100
19. California	135	44. Louisiana	100
20. New Mexico	135	45. North Carolina	95
21. Arizona	130	46. Missouri	90
22. Illinois	130	47. Massachusetts	85
23. Texas	130	48. Virginia	85
24. Kentucky	130	49. Tennessee	80
25. Minnesota	125	50. Florida	75
		51. Connecticut	75

Medical Defense and Insurance

Paul J. Kreutz, M.D., Chairman, Elizabeth

(Reference Committee "C")

In 1974, the major changes affecting our plans administered by E. & W. Blanksteen were as follows:

1. The Major Expense Plan was increased to \$250,000 maximum payment (from \$25,000) to be effective March 1st 1975.
2. EPIC Homeowner's was approved making available Homeowner's insurance through the Aetna Life & Casualty Company at a 10% to 12% discount.

Details of all the plans, including the new and improved ones, follow:

ACCIDENT AND HEALTH INSURANCE

The Society's Accident and Health insurance programs are administered by the E. & W. Blanksteen Agency, Inc., who have just completed their 45th year of service to our members. This comprehensive disability income program now affords a monthly benefit up to \$3,600 a month during total disability due to injury or sickness. The program consists of two parts: The Basic-Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic Plan pays up to five years; the Basic-Extended plan up to lifetime; and the Long Term plan up to lifetime. For a sickness disability, the Basic plan pays up to two years; the Basic-Extended plan up to seven years; and the Long Term plan up to age 65 and beyond. Both the Basic-Extended Plan and the Long Term plan are underwritten by the Nationwide Mutual Insurance Company. Members may carry up to \$3,600 of which up to \$1,200 may be in the Basic-Extended Plan. Up to three policies are issuable to any member for maximum flexibility. The Company will re-arrange policies and existing coverage to accommodate changing needs within the 3-policy limit.

BASIC-EXTENDED PLAN

The Basic Disability Plan provides as much as \$1,200 monthly benefit with the Nationwide Mutual Insurance Company. Benefits are

payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan where benefits could begin on a later date than 1st day accident and 8th day sickness.

The plan also pays, at half the monthly rate, accident partial disability benefits for as long as six months. Also included in the plan are accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime and sickness benefits extended for an additional five years, for a total of seven years. There are 5,184 basic policies covering our members with some members having two basic policies. It is the Administrator's practice to combine two basic policies into one whenever members revise or increase their insurance programs so as to simplify their record-keeping.

LONG-TERM PROFESSIONAL INCOME PROTECTION PLAN

Members may now carry up to \$3,600 under this plan less the amount carried under the Basic-Extended Plan. Benefits are payable for lifetime for accident total disability and to age 65 and beyond for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place; such as annuities, life insurance settlement options, and social security. The plan also affords six months of accidental partial disability at half the monthly benefit rate. Benefits may begin from the 31st, 61st, 91st or 181st day of disability, with appropriate reductions in premium. Currently 1,598 members participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to

insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for Federal Income Tax purposes. Members who apply for the Basic-Extended Plan within their new member periods are insured coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided for in doctor's original policy.

MAJOR EXPENSE PLAN

Our Major Expense Plan was improved (effective March 1, 1975) by the addition of the "Quarter Million" Dollar Rider extending coverage beyond the \$25,000 limit of the base policy to \$250,000 for members below Medicare age.

Until \$25,000 has been paid on any claim, the room and board rate is \$100 daily for intensive care and \$50 for all other accommodations. The private duty nursing benefit takes into account as covered expense \$24 for each eight-hour shift. (RN or LPN in the hospital; RN at home.) Also, certain services and supplies both in and out of hospital are covered. After a \$750 deductible for each benefit period, 80 percent of Covered Expenses are paid up to a maximum of \$25,000. There is *no* coordination-of-benefits provision for those below Medicare age! After the base policy has paid \$25,000 and the claim continues, the "Quarter Million" Dollar Rider takes over with expanded coverage (since primary hospital plans may be exhausted by this time). Hospital room and board coverage is now full semi-private cost (up to double for intensive or coronary care units) and covered nursing charges are paid-in-full. The services and supplies covered by the base plan continue to be covered by the Rider, 100 percent of covered expense is reimbursed and benefits are *not* reduced because of other non-government coverage.

Every policyholder will receive the March 1, 1975 renewal notice with a Rider for participants under Medicare age. Upon payment of the low additional premium, the Rider will go into effect on a non-medical basis. No application is necessary for present policyholders and presently covered dependents.

The program now covers 2,470 members with many members including coverage for their wives and children. New members to the Society may obtain coverage under the Major Expense Plan without regard to medical history provided they apply within their allotted two-month new member period. E. & W. Blanksteen Agency, Inc., administers this plan.

HOSPITAL-MONEY PLAN

Our Hospital-Money Policy, administered by E. & W. Blanksteen Agency Inc., provides \$20, \$30, \$40, \$50, or \$60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse and dependent children. New members are able to obtain the \$20 a day program non-selectively as part of their new-member privilege. Three hundred twenty-eight members participate in this program.

EPIC AUTOMOBILE INSURANCE PROGRAM

The Society has adopted the EPIC Automobile Insurance Program of the Automobile Insurance Company of Hartford — administered by E. & W. Blanksteen — as a solution to the problem many members had of paying high automobile insurance premiums and the inability of some of our members to obtain adequate coverage at any price. We are the first medical society in the country to offer this low-cost, guaranteed issue automobile insurance plan to its members and their employees. The EPIC Plan of the Automobile Insurance Company of Hartford has the following characteristics:

Four out of five applicants will save 5% to 15% (and in some cases up to 40%) of their present insurance cost.

One out of five *may* pay more (because of driving record, etc.) but will get full coverage.

Five out of five members who hold a valid driver's license and participate in the Authorized Check Plan will be guaranteed a policy that they will have the sole option of accepting.

A key part of the program is the direct servicing of claims by company claim offices and the convenient Authorized Check Plan whereby premiums are automatically deducted monthly (without extra charge!) from your checking account. Up to \$1,000,000 bodily injury and property damage coverage is available with all the other important coverage available at your option. No-Fault reductions and special No-Fault coverage are, of course, provided under the Plan.

Some of the savings, members have realized under the Plan, are impressive and we would certainly urge other members to obtain a non-obligation quotation from our Administrator to see whether or not they can participate in similar savings. Currently 236 members are insured under the program.

OVERHEAD EXPENSE PROGRAM

Many of our members find that their overhead expenses have become quite high, with employees' salaries, rentals and other fixed expenses pertaining to their practice. Our Professional Overhead Expense Program is underwritten by the National Casualty Company and administered by the E. & W. Blanksteen Agency, Inc. It provides up to \$2,500 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years. This program will be offered in a special non-selective enrollment and if during this enrollment period 1,500 of our members under the age of 60 will apply there will be a guaranteed issue of at least \$500 monthly benefit — provided only that they are members of the Society in the full-time active practice of medicine and are under age 60 at the time the policy is issued. At the end of last year, 280 applications toward the quota had been received as a result of the pre-enrollment announcement.

In accordance with IRS regulations, the premiums under this program are considered business expense *and are tax deductible*.

LIFE INSURANCE — NATIONWIDE LIFE INSURANCE COMPANY AND BANKERS LIFE COMPANY OF DES MOINES, IOWA

The maximum coverage under our Life Plan is \$250,000 with the \$100,000 maximum coverage Bankers Life Plan available in addition to the \$150,000 program of the Nationwide Life Insurance Company that has been in effect for many years.

Our original Nationwide Life Insurance Program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21, up to age 26 if a college student), as well as employees. An important feature of this expansion is that each person will have his own Five Year Renewable and Convertible Term Policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The Nationwide life program provides each insured person with a Five Year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now provides up to \$150,000 of coverage for members and up to \$50,000 of coverage for spouse, dependent children, and employees. All coverage is issued in the form of convenient units of \$10,000 with Waiver of Premium and Double Indemnity for accidental death included without premium charge. Since inception of the program, there have been 272 death claims, resulting in a total pay-out of \$2,897,400.

As a result of the large volume of insurance and strong participation of our members in this program we are able to have non-cancellable term life insurance at a very low cost. At the present time, over 1,800 of our members participate in the program with approximately \$30,-185,000 of insurance currently in force. This plan is also available to spouses, children, and employees and 100 of them participate in this program.

The additional \$100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible larger amounts of insurance without the necessity of another physical examination and give our members even greater flexibility in establishing their insurance program. The net cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above.

One hundred and eight of our members have applied for and were issued \$3,910,000 of insurance protection under this new plan, as of January 1, 1975.

SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE PLAN

Our Six Point, High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company, administered by E. & W. Blanksteen Agency, Inc., provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance and even a total disability feature, at less than the usual cost of the accidental death benefit alone.

Special spouse coverage is available under this policy at very low cost. Seven hundred eighty-six of our members participate in this program.

EPIC HOMEOWNERS INSURANCE PLAN

This program is needed by any physician who owns his own home or rents an apartment (to provide homeowners or renters insurance). Application for the EPIC Homeowners Insurance Program endorsed by The Medical Society of New Jersey is available to any physician regardless of age, who is an active member of the Society or has applied for membership. Employees of members may also participate in the plan.

To choose a plan, you simply advise the administrator as to the type and amount of coverage you desire by completing the short "Request for EPIC Homeowners or Renters Premium Quotation" form and returning it to

the Administrator. They will then send you a quotation which you can compare with your present coverage.

Following is a brief outline of the coverage: (For more complete information ask the administrator for a brochure which describes the program — and contains a "Request for EPIC Homeowners or Renters Premium Quotation" form.)

EPIC Homeowners insurance costs on the average of 5% to 15% less than comparable insurance bought elsewhere for most members.

Automatic Cost-of-Living adjustment (homeowners only) whereby once a year your EPIC protection is adjusted up or down to reflect the cost of living. There may also be a slight adjustment in your premium.

The EPIC policy provides a wide range of coverages as described in the brochure.

If your insurance is maintained at 80% or more of replacement cost, all insured losses will be paid in full up to the limits of the policy. (Does not apply to tenants coverage).

Housegoods are covered for 50% of your home insurance; \$50,000 personal liability protection, including \$500 medical payments. Higher limits are available.

Local claim service with almost 300 locations throughout the country.

Guaranteed convertible if you terminate the association which makes you eligible for EPIC.

To obtain a no-obligation quotation, a member or his employee need only complete a "Request for EPIC Homeowners or Renters Premium Quotation" form. The savings can be substantial and well worth the time it takes to fill in the form. This program is administered by E. & W. Blanksteen and underwritten by Aetna Life and Casualty Company.

PROFESSIONAL CORPORATIONS

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended, Long Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Six-Point High Limit Accident Insurance Plan, EPIC Automobile Insurance Plan, Overhead Expense Plan, and Life Insurance Plan, has advised that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

Recommendation

That the E. & W. Blanksteen Agency, Inc., be continued as the official broker for MSNJ's Accident and Health, Major Expense, Hospital-Money, Life, High-Limit Accident, Automobile Insurance, Professional Overhead Expense, and Homeowners Insurance Programs.

Approved (page Tr 118)

PROFESSIONAL LIABILITY

During the past year, your Committee was involved in exploring areas to solve some of the problems related to medical professional liability and the effects of inflation and other influences on our program.

The overall costs increase of 20 percent for 1974 accepted by the Board of Trustees and the 1974 House of Delegates was approved by the New Jersey Department of Insurance effective 17 June 1974. The class allocations approved by the Insurance Department resulted in substantial increases for orthopedics and neurosurgery. During the past year, discussions and meetings took place with members from these specialties to explore the facts behind the dramatic increases and to evaluate suggestions for alternate courses of action. Detailed information was provided to assist in development of loss control activities within the specialties.

Regarding the current program, the Committee took the following actions:

1. Agreed to reduce the maximum premium surcharge for adverse claim experience from 500% to 200% subject to approval by the Insurance Department.
2. Reaffirmed the position that arbitration has not been proved to be a viable replacement of the present system for adjudication of medical professional liability claims.
3. Agreed to a program for insuring interns and residents, for their hospital-related activities, when the company insuring the hospital would no longer be willing to provide coverage.
4. Agreed to permit coverage, under the program, for doctors of osteopathy who are in a partnership or a shareholder in a professional corporation with member(s) of our society covered by the program.
5. Provided the chiefs of staff of all general hospitals with booklets containing recommended medicolegal forms for use within the hospitals.

There were other major issues given in-depth evaluation. One important issue is the need for

legislative relief to stem the continuing deterioration in medical-malpractice defense due to liberal interpretations of statutes and case law which is becoming increasingly apparent. Understandably, this problem will concern the insurance industry and would correspondingly affect our program.

The Committee, in cooperation with the Council on Legislation, evaluated a series of proposals whose objectives were to establish realistic limitations on the amount of liability on the part of physicians; to change the "informed consent" burden effecting good practice; to provide a realistic statute of limitations; to return the "burden of proof" to the plaintiff; as well as otherwise aid in defense of malpractice claims. It was recognized that a number of these proposals have merit and affirmative action was recommended. More studies will be conducted which will include input from county societies, medical review committees and others involved in our professional liability program, so that additional recommendations can be developed.

Physicians in many states are subject to various problems as many insurance companies are withdrawing from writing professional liability insurance, making new restrictive forms of policies mandatory, or drastically increasing rates (drastic as compared to our rate increases). The reasons behind these changes are clear. Inflation in itself is an important factor but not the sole reason. One problem is the difficulty in developing adequate premium due to the "long tail" factor so predominant in malpractice. The companies report substantial losses resulting from the rapid escalation in claim settlements partially due to higher medical costs and inflated wages as well as the increasing amounts of jury awards. There appears to be a marked increase in the number of claims, partially due in some states to no-fault automobile insurance which has reduced auto claims for attorneys. Another factor is the substantial decline in insurance company investment portfolios which precludes assumption of high-risk forms of insurance, such as medical malpractice.

In our program, we have seen the effect of larger settlements and verdicts and the insurance company proposed a new actuarial table to develop adequate premium at limits of \$100,000/300,000

and above. The Committee reviewed the new table which was more realistic when considering the various levels of current settlements and verdicts. It would have the effect of increasing premiums approximately 24 percent overall. The company was permitted to file these new factors when it was agreed that this modification would be considered along with other suggested changes for 1975 when determining what final costs should be. The filing was made but the new table has not yet been approved by the New Jersey Department of Insurance and the Committee is unable to predict, at the present time, what the final action will be. Consequently, the Committee is also temporarily precluded from exploring additional areas and recommending other changes which may be desirable this year. If additional information becomes available in this area prior to the convention, a supplemental report will be submitted.

Inflation and other adverse developments have had an unfavorable effect on our "umbrella" coverage. The company which has provided this coverage since 1970 has stated that it will not accept new or renewal policies after 1 July 1975, paralleling the actions taken by a number of other companies. Extensive contacts with many insurance companies have been made in order to locate a new acceptable carrier. It appears that we will be able to provide this coverage and details will be included in a supplemental report.

The legislative bill A-1552 creates a "Professional Liability Insurance Facility" under control of the Department of Insurance. This concept would force all companies providing professional liability insurance in any other state and writing various forms of liability insurance in New Jersey to offer malpractice coverage to all providers of health care. The proposed bill requires all physicians to carry certain limits of coverage to be eligible for licensure and relicensure. The Committee felt this bill should be resisted in that it would emasculate, if not destroy, our present program; that it overlooked the fact that our members do not have a problem regarding availability of insurance; that it could lead to much higher premiums in a few years; and that it placed new controls and burdens on the practice of medicine.

The 24 February 1975 issue of the *AMA News*

gave a report on the status of medical professional liability insurance in all of our states. It pointed out the problems in many of the states and showed one or more problems for most of the states. The major problems were as follows:

1. The primary carrier was withdrawing completely from the state with no other company willing to take its place.
2. The primary carrier would write insurance for only selected physicians leaving many unable to secure any coverage.
3. The primary carrier would continue only on a "claims made" basis at the same existing rates. This would mean that the physician's insurance applied only during the period he was insured by the company. Lloyds, at present, will extend coverage for two years after termination of the insurance by decision of the company or the insured, or death. This would eliminate the problem of the "long tail" for the company but would give no protection for actions brought after a few years which is not unusual. Some companies would provide extended coverage for the "long tail" claim upon termination of the coverage but at a comparatively high cost which could mean an increase of 100% or more.
4. Substantial rate increases, some of which far exceeded 100%.

This report gave or indicated the costs for this insurance coverage in the states and it is interesting to note that New Jersey ranks eighteenth in costs levels which means that there are thirty-two states with higher costs with some having one or more of the major problems as well. Of the seventeen with costs lower than New Jersey, fifteen have major problems. A copy of this analysis appears on the next page.

The Committee believes that this is the greatest proof of the tremendous success of our program. Without this program, New Jersey probably would be in the same position as the other populous and highly industrialized states and our problems would not be limited to increasing costs for insurance. We also feel that this report proves that if the Department of Insurance's Bill A-1552 is enacted, within a few years we could rank somewhere between 40 and 50 on a similar report of comparative costs.

Recommendation

That the Joseph A. Britton Agency be continued as MSNJ's Official Broker for its professional liability coverage.

Approved (page Tr 118)

AMA Survey of All States — March 1975

	<i>St. Paul Argonaut</i>	<i>Cost 100/300</i>	<i>Problems</i>	<i>State</i>
1	SP	872	X	North Carolina (No coverage after 7/1/75)
2	SP	924	X	Mississippi
3		984		Oklahoma
4		1,010		South Carolina
5		1,209		Rhode Island
6	SP	1,530	X	Georgia
7		1,692	X	Alabama
8	SP	1,800	X	North Dakota
9	SP	2,196	X	Minnesota
10	SP	2,273	X	Maryland (Coverage given under Court Order.)
11		2,400	X	Missouri
12	SP	2,586	X	Nebraska
13	A	2,700	X	Hawaii
14	SP	2,728	X	Virginia
15		2,750	X	Kansas
16	SP	2,840	X	Louisiana
17	SP	3,130	X	Arkansas
18		3,227		NEW JERSEY
19		3,285	X	Tennessee
20		3,350		New Mexico (74% increase 7/1/75)
21	A	3,385	X	Pennsylvania (250% increase requested)
22	A	3,571	X	Nevada (300% increase after 7/1/75)
23		3,590		Colorado (\$1,000,000. coverage)
24	A	4,000	X	Massachusetts (300% increase requested)
25		4,080	X	Maine
26		4,430		Vermont
27		4,551	X	Michigan
28		4,656	X	Iowa (25/75 coverage)
29		5,133	X	Wisconsin
30		5,258	X	Connecticut
31		5,749		West Virginia
32		5,885	X	Kentucky
33	SP	6,000	X	South Dakota
34		6,186		Utah (Ortho — Neuro Surg)
35	A	6,264	X	Idaho (250/500 coverage)
36		6,297		Delaware
37		6,356		Washington
38	A	7,096	X	North California (Travelers is retiring)
39		7,116	X	Illinois
40		7,240	X	Oregon
41		7,504		Montana
42		7,532	X	Ohio
43		7,865		Wyoming (250/500 coverage)
44		8,000	X	Texas
45	A	8,243	X	Florida
46		9,000	X	Alaska
47		9,119		Arizona
48	A	14,329	X	New York (Orthopedists)
49		?	X	Indiana (6 companies writing under pressure)
50		?	X	New Hampshire

St. Paul will write only on "claims made" effective 7/1/75.

Argonaut — Probably no coverages after 12/31/75.

STATEWIDE BLUE CROSS-BLUE SHIELD PROGRAM

Since the last annual report, the Middlesex County Medical Society has joined the Blue Cross-Blue Shield Program, increasing the participating county medical societies to 15.

Employees of physicians became eligible for coverage on August 1, 1974. This made it easy for physicians to provide their employees with the same expanded benefits under one invoice.

These additional enrollments have brought the

Group total to over 4,300.

In order to enroll your employees, there are certain participation requirements which must be met. If an employer unit has five, or fewer, full-time employees, all employees must enroll (or be a dependent of someone enrolled in another Blue Cross-Blue Shield Plan). For units with more than five employees, 75 percent of the eligible employees of each unit must enroll. Again, credit is given for employees who are protected by New Jersey Blue Cross-Blue Shield under another plan. In addition, each employer must contribute at least the single premium rate for each of his/her employees.

January 1, 1975, a new higher surgical benefits schedule was adopted. This is known as the "750 Series Surgical Schedule." It provides approximately 45 percent higher benefits than the existing "500 Series." Over 50 percent of our participating physicians elected the higher benefits schedule.

There was a small rate increase on July 1, 1974, amounting to 7/10th of 1 to 1.5 percent for those under age 65, and 3.9 to 6.8 percent for those over age 65. Since your premiums are based on your claims experience, we feel fortunate that your increase was so slight, even in the face of rising medical costs.

Recommendation

That Donald F. Smith and Associates be continued as MSNJ's Official Broker for its Blue Cross-Blue Shield Program.

Approved (page Tr 118)

Filed (page Tr 118)

Supplemental Report

PROFESSIONAL LIABILITY

1. November 1, 1975 Rates

At a meeting on May 28, 1975, the Committee on Medical Defense and Insurance considered cumulative loss data from November 1960 through May 1, 1975, which clearly established

extensive losses under the professional liability insurance program. The carrier has requested the following rate increase which will be applicable to all classes of practice and the Committee **recommends** approval.

Increase in Limits Factors —	24.3%
Additional Increase —	23.7%
Total	48%

Approved (page Tr 119)

2. Umbrella Policy

The broker has advised that efforts to produce an umbrella carrier for professional liability policies have produced one willing carrier and one very interested carrier whose rate filing is pending before the Department of Insurance.

Recommendation

That the Joseph A. Britton Agency be authorized to place the coverage for the umbrella policies with the carrier that offers the best advantages to MSNJ members.

Approved (page Tr 119)

3. Education of Physicians

Recommendations

a. That MSNJ urge the College of Medicine and Dentistry of New Jersey to present mandatory courses on professional liability in the medical school curriculum.

Approved (page Tr 119)

b. That the AMA urge such curriculum inclusions in the nation's medical schools.

Approved (page Tr 119)

4. Remedial Legislation

The Committee notes with pleasure that five bills drafted by MSNJ have been presented for introduction and that further drafts are being prepared.

Recommendation

That MSNJ aggressively initiate an educational

program directed toward the Governor, the legislature, and the public to secure support for remedial legislation.

Approved (page Tr 119)

Supplemental Report amended by the Reference Committee to include the following additional recommendation under "Remedial Legislation:"

That The Medical Society of New Jersey actively seek the cooperation of the State Supreme Court making mandatory use of Supreme Court Panels under Rule 4:21 which now exist in the State for investigating professional liability insurance claims.

Approved as amended by the Reference Committee (page Tr 119)

Medical Education

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "D")

The Committee on Medical Education has had a year of increased activity brought about by the many new responsibilities in this rapidly expanding area. Three meetings have been held during the past year to discuss the many aspects of the mandatory continuing medical education requirement for membership in MSNJ and to implement the program as rapidly as possible. As with any new program, many unforeseen problems appeared and were solved as a result of the diligent efforts of all the Committee members with the aid of a loyal and diligent staff.

The Committee has received a total of 74 applications from hospitals requesting accreditation surveys and 46 surveys have been completed. The accredited hospitals are as follows:

Alexian Brothers	Monmouth Medical Center
Atlantic City	Montclair Medical Center
Bayonne	Mountainside
Burlington Co. Memorial	Muhlenberg
Christ (Jersey City)	Newark Beth Israel
Clara Maass Memorial	Newcomb
Carrier Clinic	Overlook
Cooper	Pascack Valley
Columbus	Perth Amboy General
East Orange General	Roosevelt
Elizabeth General	Somerset
Englewood	St. Clare's
Essex County	St. Elizabeth
Hackensack	St. Francis Medical Center
Helene Fuld	St. Joseph's
Holy Name	St. Michael's Medical Center
Center at Orange	Underwood-Memorial
Margaret Hague Maternity	United Hospitals of Newark
Medical Center (Princeton)	VA Hospital (East Orange)
Martland	Warren
Millville	West Jersey

While the number of completed surveys is an accomplishment, at the present time we still have 26 hospitals to be surveyed. The survey teams gave freely of their time to visit the hospitals, talk with all the involved personnel, review the facilities, and then render cogent reports to the hospital staff leaders as well as to the Committee on Medical Education, so that a proper decision could be made. The entire Medical Society of New Jersey owes these men a great debt of gratitude for their devotion, sincerity, perspicacity, and the prompt fulfillment of a most difficult task. They are listed for your proper commendation:

Alfred Alessi, M.D.	Edward MacDonald, M.D.
Michael Bernstein, M.D.	Otto Matheke, M.D.
William Black, M.D.	Donald McDonald, M.D.
Matthew Brady, M.D.	Francis McGinn, M.D.
Frank Camp, M.D.	Brewster Miller, M.D.
Everett Curran, M.D.	William Minogue, M.D.
Rudolph DePersia, M.D.	John Movelle, M.D.
Maurice Elovitz, M.D.	Warren Nestler, M.D.
James Fitzpatrick, M.D.	Robert Neville, M.D.
Michael Friedman, M.D.	Howard Nunes, M.D.
Robert Garber, M.D.	Daniel O'Connell, M.D.
Sherman Garrison, M.D.	Lawrence Owen, M.D.
Thomas Gocke, M.D.	Robert Parvin, M.D.
Melvin Goldberg, M.D.	Donald Peyser, M.D.
William Greifinger, M.D.	Stanley Pomerantz, M.D.
Abdol Islami, M.D.	Charles Ream, M.D.
Paul Johnson, M.D.	James Rogers, M.D.
John Kangor, M.D.	Morton Rosenblatt, M.D.
Norval Kemp, M.D.	Leo Siegel, M.D.
Donald Kent, M.D.	Leon Smith, M.D.
Seymour Kuvin, M.D.	Frank Snope, M.D.
Kendrick Lance, M.D.	John Thompson, M.D.
Nicholas Laurora, M.D.	William Vaun, M.D.
Arthur Lewis, M.D.	John Verdon, Jr., M.D.
George Lordi, M.D.	Sidney Woltz, M.D.
Adam Wychulis, M.D.	

The following hospitals will be surveyed as soon as possible:

Alexander Linn	Mercer Medical Center
Barnert Memorial	Middlesex General
Bridgeton	Newton Memorial
Chilton Memorial	Point Pleasant
Deborah Heart and Lung	Rahway
Dover General	Riverside
Freehold Area	St. Francis Community
Greenville	St. Mary's
Irvington General	St. Peter's General
Jersey City Medical Center	St. Vincent's
Jersey Shore	The Valley Hospital
John F. Kennedy	Trenton Psychiatric
John E. Runnells	Wm. B. Kessler Memorial

Several of the above hospitals are in the process of being scheduled for survey which will be completed by the time of the Annual Meeting.

Based on our experience of the past year, the Committee requested the Board of Trustees to approve a \$350 re-survey fee. Team members were giving a good portion of a full day, voluntarily without reimbursement, and it was felt that they should at least be reimbursed in part for their time and travel. Furthermore, the program was not without expense to the Society. The Board concurred and so directed that an application fee of \$350 be established for all requests for survey received after January 1, 1975. In November all hospitals in New Jersey were notified of this change.

The Committee has worked in liaison with the Academy of Medicine of New Jersey and *The Journal* in publishing each month an extensive calendar "Meetings of Medical Interest." This listing provides the membership of MSNJ with advance notice of meetings held throughout the State which are eligible for CME credit.

Presently the Committee is working on the development of a computerized program to document physician attendance at meetings. Inquiries are being made to Hoffmann-LaRoche, Inc., the AMA, and to states already having a computerized system in use. As soon as the most feasible means to accomplish this has been determined, an accountability system will be initiated.

In the interim the ROCOM Division of Hoffmann-LaRoche has provided the Committee on Medical Education with a pocket-sized "Physician's Recognition Award Record

Book" for use by physicians in recording their CME credits. This, along with a file folder and additional recording sheets for their personal files, will be provided by MSNJ and distributed to all physicians registering at the Annual Meeting.

The Committee has set about the task of developing rules and regulations for proper methods of notification appeal, and so on, for physicians who fail to comply with the compulsory CME requirement by 1976. These rules will be promulgated once they have been properly drawn up and approved by the Board of Trustees.

The Committee, through the efforts of Dr. Elovitz, has been investigating the use of audio-visual techniques for use by the individual physician as well as by hospital staffs in their continuing medical education programs, as a supplement to other teaching methods. This will be pursued in the coming year.

Many requests for exemption from the CME requirement have been received by the Committee and each has been reviewed individually. For active members, disability or illness has been the only basis for exemption to date. The requirements of the program are not meant to work a hardship on any member and hopefully will forestall any future mandatory program by the Federal Government.

The Committee gratefully acknowledges the cooperation of the many physicians who volunteered both their time and effort to enable us to complete as many accreditation surveys as we did, as well as the cooperation of the hospitals involved. We would also like to express appreciation to the ROCOM Division of Hoffmann-LaRoche for their generosity in donating the CME record book for distribution to our membership.

The Chairman personally is most grateful to the Committee members, Alfred A. Alessi, M.D., Maurice J. Elovitz, M.D., Howard L. Nunes, M.D., Frank C. Snope, M.D., and Edward H. Weiser, M.D., and the staff for their devotion, patience, and continuous flow of stimulating ideas.

Filed (page Tr 121)

Medical Student Loan Fund

William Greifinger, M.D., Chairman, Essex

(Reference Committee "B")

In its eighteen years of operation the Medical Student Loan Fund has granted loans totaling \$397,644.35 including \$444.35 as insurance payments, bringing the net loans granted to \$397,200.

To date the Fund has issued 343 loans to 212 New Jersey medical students. One hundred and twenty-seven loans have been repaid in full. Twenty-six borrowers are presently making quarterly repayments on an annual basis.

Thirty-three requests for financial assistance by New Jersey medical students were received during the 1974-75 administrative year, and twenty-five loans in the amount of \$1,500 each were granted for a total of \$37,500. It is expected that this trend will continue for some time.

It is estimated that the Fund will have \$47,000 available for loans for the 1975-76 school year to accommodate thirty-one students at \$1,500 each. Of this amount \$9,000 is committed to six

prior applicants, leaving \$38,000 for twenty-five additional student requests.

This report does not reflect all the anticipated applications from other qualified medical students and your Committee is also mindful of the ever-increasing tuition rates. However, at this time, it does not feel it can afford to increase the \$1,500 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients now serving an internship or residency to initiate early repayment of their loans on an interest-free basis. This year twenty loans have been paid in full. (20 @ \$1,000 — \$20,000). The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends and thanks Mr. Lambert and Mr. Squireck for their consistently efficient administrative assistance.

DISTRIBUTION OF LOANS

County of Residence	Medical School	Students	Loans Granted	
			1957-74	1974-75 March 31, 1975
Atlantic	Hahnemann	3	\$ 3,000.00	
	N.J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Temple	1	1,000.00	
	Tufts	1	4,000.00	
Bergen	Boston	1	1,000.00	
	Creighton	1	1,000.00	
	Hahnemann	3	5,000.00	
	Jefferson	2	4,500.00	
	Med. Coll. Pa.	1		1,500.00
	N.J. Medical	9	14,000.00	
	N.Y. Medical	4	2,500.00	3,000.00
	Rutgers	1	1,500.00	
	St. Louis	2	3,000.00	
	Stritch	1	3,000.00	
Burlington	Tufts	1	1,500.00	1,500.00
	Duke	1	4,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	3	9,500.00	
	Med. Coll. Pa.	1	1,500.00	
Camden	Hahnemann	4	6,500.00	
	Jefferson	3	5,000.00	1,500.00
	Michigan	1	2,000.00	
	N.J. Medical	2	2,700.00	
	Temple	5	7,500.00	

Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	4,000.00	
	Bern	1	2,000.00	
	Duke	1	2,000.00	
	Georgetown	3	2,500.00	1,500.00
	Hahnemann	4	8,000.00	1,500.00
	Howard	1	300.00	
	Jefferson	1	3,000.00	
	N.J. Medical	21	41,400.00	3,000.00
	N.Y. Medical	2	2,000.00	
	Stanford	1	3,000.00	
	St. Louis	1	500.00	
	Temple	1	1,000.00	
Gloucester	Hahnemann	1	1,000.00	
	Temple	1	2,000.00	
	Virginia U.	1	1,000.00	
Hudson	Boston	1	3,000.00	
	Georgetown	1	1,000.00	
	George Washington	1	3,000.00	
	Hahnemann	1	1,500.00	
	Harvard	1	1,000.00	
	Howard	1	400.00	
	Med. Coll. Pa.	1		1,500.00
	N.J. Medical	22	33,150.00	4,500.00
	N.Y. Medical	1	1,000.00	
	Pittsburgh	1	3,000.00	
	St. Louis	1	2,000.00	
Hunterdon	5th Channel Prog.	1		1,500.00
	Rutgers	1	1,500.00	
Mercer	Georgetown	2	3,000.00	1,500.00
	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1	1,000.00	
	Louisville U.	1	4,500.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N.J. Medical	5	9,500.00	
	N.Y. Medical	1	1,500.00	
	Pennsylvania U.	1	1,000.00	
	St. Louis	1	700.00	
	Tufts	1		1,500.00
Middlesex	Wisconsin Med.	1		1,500.00
	Georgetown	1	1,500.00	
	Hahnemann	1	4,000.00	
	Stritch	1	1,500.00	
	Rutgers	1	3,000.00	
	N.J. Medical	1	1,500.00	
	N.Y. Medical	2	1,500.00	3,000.00
	Wisconsin Med.	1	1,500.00	
Monmouth	Columbia	1	2,000.00	
	Duke	1	3,000.00	
	Einstein	1	1,500.00	
	Georgetown	1	1,000.00	
	Jefferson	2	6,000.00	
	Marquette	2	3,500.00	
	Med. Coll. Pa.	1	1,500.00	
	N.J. Medical	3	10,000.00	
	N.Y. Medical	1	4,000.00	
	Stritch	1	4,500.00	
	Temple	1	2,000.00	
	Up-State N.Y.	1	1,000.00	
Morris	Case Western	1		1,500.00
	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	N.J. Medical	3	6,000.00	1,500.00
	Stritch	1	1,500.00	

Ocean	Med. Coll. Pa.	1	3,000.00	
	Rutgers	1	1,500.00	1,500.00
	Tufts	1		1,500.00
Passaic	Jefferson	1	3,000.00	
	N.Y. Medical	1	1,000.00	
	Wisconsin Med.	2	3,000.00	
Salem	Duke	1	1,500.00	
	Jefferson	1	3,000.00	
Somerset	Georgetown	1	1,000.00	
	N.Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Florida	1	1,000.00	
	Hahnemann	2	1,000.00	1,500.00
	Jefferson	1	1,500.00	
	N.J. Medical	12	20,800.00	
	N.Y. University	2	4,500.00	
	Wisconsin Med.	1	1,500.00	1,500.00
18 Counties	38 Medical Schools	212	\$359,700.00	\$37,500.00
Total loans granted 3/31/75				\$397,200.00

PRESENT LOCATION OF RECIPIENTS OF LOANS

The 100 graduates are located as follows:

Interns — 3 in New Jersey and 6 out-of-state9

Residents — 14 in New Jersey and 26 out-of-state ...40

Armed Service — 4 Army of the United States and
6 United States Navy10

Private Practice — 2 Arizona, 5 California, 1 Connecticut, 1 District of Columbia, 1 Florida, 1 Massachusetts, 1 Mississippi, 14 New Jersey, 6 New York, 2 North Carolina, 1 Oregon, 3 Pennsylvania, 1 Texas, 1 Virginia and 1 Wisconsin41

Students presently in medical school — 20 seniors, 6 juniors, and 1 fifth channel program27

Current student loans outstanding127

Medical students paid in full (127 loans)85

Total New Jersey Medical Students
(as listed earlier)212

CONTRIBUTIONS

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; New Jersey Foundation for Health Care Evaluation; County Medical Societies: Burlington, Cape May, County Woman's Aux-

iliaries: Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Monmouth, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren. Mrs. Louis Abbamonte, Dr. Floyd J. Donahue, Dr. and Mrs. Sol S. Ellenson, Dr. David Eckstein, Dr. and Mrs. Paul Ferrary, Dr. and Mrs. Philip Fiscella, Dr. Joseph R. Jehl, Dr. and Mrs. John Kustrup, Evelyn A. Lawrence, Dr. and Mrs. Samuel J. Lloyd, Mr. V. Mitchell, Marcella Mulligan, Dr. and Mrs. John Scillieri.

In Memory of:

Dr. Robert C. Anderson, Constance Bono, Dr. Francis B. Brogan, Dr. Louis K. Collins, Ida DiLorenzo, Robert Dilworth, Sarah Dilworth, Dr. William E. Dodd, Mother of Dr. Nathan Epstein, Fred Frei, Dr. Floyd Gindhart, Dr. John Haney, Otto Hessmer, Juanita Holt, Sadye Hornstine, Lulu Hughes, Dr. Jules J. Klain, John G. M. Konzelman, Albert Barker Kump Memorial, Dr. Louis Landaw, Dr. J. Stauffer Lehman, Sr., Dr. Anthony J. Lettiere, Bertha Levinsohn, Dr. Harry B. Mark, Dr. Vincent Martin, Edward Merrey, James H. Osborne, Norman M. Peters, Sr., Dr. Carl L. Pierson, Mrs. Samuel Salasin, Joy Santanello, Nicholas Scielzo, Dr. Edward W. Sprague, May Taylor, Edith Vandermann, Dr. Samuel E. Watov, Dr. William C. V. Wells, Mrs. Asher Yaguda.

In Honor of:

The Medical Society of New Jersey, Board of Trustees, Dr. Harry Hutchinson, Son of Dr. and Mrs. Neal Krosney, MSNJ's Woman's Auxiliary Executive Board.

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee — approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1975-76 in support of the Medical Student Loan Fund.

Approved (page Tr 117)

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved (page Tr 117)

(c) That the Woman's Auxiliary to The Medical Society of New Jersey be requested to make the Fund its number one project next year.

Approved (page Tr 117)

Filed with commendation to the Chairman and his Committee members (page Tr 117)

Publication

Daniel B. Roth, M.D., Chairman, Teaneck

(Reference Committee "B")

The Publication Committee has had a busy year. Under the able leadership of our Editor, Dr. Arthur Krosnick, *The Journal* has taken on a new look. Three Associate Editors, Doctors Dwyer, Pinck, and Rapkin, have been appointed and a large Manuscript Review Board has also been added to our staff.

We had a change in printers and in printing methods. *The Journal* is now printed in photo-offset by the Dartmouth Printing Company, which should prove technically and economically beneficial.

Effective with the July issue, we will be represented by a new advertising group, United Media Associates, Inc., which should help us to improve our advertising position and help to

defray some of the publication costs.

We are planning a special Bicentennial program for 1976 to include a number of historical articles and an appropriate new cover. Dr. Fred Rogers and Dr. Morris Saffron, who are experts on medical history, have consented to assist the Editor in obtaining papers from the Third New Jersey Medico-Historical Symposium to be held in the fall of 1975, for use in the January 1976 issue. This will contain a series of articles on the activities of physicians during the Revolutionary War era. Each subsequent issue during 1976 will contain at least one paper on medical history.

We look forward to the future with confidence.

Filed (page Tr 117)

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

The Committee, after study and evaluation, submits the following report to the 1975 House of Delegates.

CONSTITUTIONAL AMENDMENTS Article IX — Officers Section 1 — Term of Office

The Committee considered the proposal submitted by the Mercer County Medical

Society. The Committee notes that, in accordance with Article XII — 9 (Amendments to the Constitution) of the current Constitution, acceptance by a majority of the House of Delegates is required for the first year procedure. The Committee believes that adoption of the measure will moderate and unify the discrepancy in tenure of certain offices within the Society and Board of Trustees.

Recommendation

That the following amendment to the Constitution be accepted.

Approved (page Tr 114)

Current

(a) The Officers, except the Judicial Councilors and the elected members of the Board of Trustees shall hold office for one (1) year, or until their successors are elected and installed.

Proposed

(a) *The President, President-Elect, First Vice-President, and Second Vice-President shall hold office for one (1) year or until their successors are elected and installed.*

(b) *Notwithstanding any other provision of this Constitution or Bylaws, the elected Trustees, the Secretary, the Treasurer, and the members of the Judicial Council shall serve no more than three (3), three (3) year terms in any of the above-mentioned offices or combination thereof.*

Article XII — Amendments to the Constitution

The proposal submitted by the Bergen County Medical Society would reduce the Constitutional Amendment Procedure from two years to one. The Committee believes that this proposal will enable the Board of Trustees and the Committee on Long Range Planning and Development to conduct an exhaustive study and evaluation of the Constitution and Bylaws with a view toward modernization, clarification, and brevity, if necessary, with the hopeful expectation that one decisive report can be submitted to the House and acted upon. Your Committee concurs in the need for such a study and revision.

Pursuant to Article XII—9 an acceptance by a majority of the House of Delegates is required for the first year procedure.

Recommendation

That the following amendment to the Constitution be accepted.

Approved (page Tr 114)

Current

This Constitution may be amended in the following manner:

Proposed

Same

A. Procedure for First Year

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than February first.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society not later than February 15.

3. Study of the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws.

4. Submission of the proposed amendment in writing at the first session of the House of Delegates.

5. Report on the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws at the first session of the House of Delegates.

6. Referral of the proposed amendment and report thereon to the appropriate reference committee.

7. Hearings on the proposed amendment and report thereon by the reference committee.

8. Report of the reference committee to the final session of the House of Delegates for appropriate action.

9. Acceptance by a majority vote of the members of the House of Delegates present and voting at the final session.

B. Procedure for Second Year

Delete

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than December 31 of the year prior to the Annual Meeting or ninety (90) days before a special meeting.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society.

3. Publication of the proposed amendment in THE JOURNAL at least sixty (60) days before said meeting.

4. Submission of the report of the Standing Committee on Revision of Constitution and Bylaws concerning the proposed amendment at the first session of the House of Delegates and referral to the appropriate reference committee for hearing and study.

5. Report of the reference committee to the final session of the House of Delegates for appropriate action.

6. Acceptance by a two-thirds (2/3) vote of the House of Delegates present and voting at the final session.

7. Delete

8. Delete

9. Delete

B. Delete

10. Transmittal of the accepted amendment to each component society and publication in THE JOURNAL, at least three (3) months prior to the next annual meeting.

10. Delete

11. Adoption by a two-thirds (2/3) vote of the members of the House of Delegates present and voting at the final session.

11. Delete

Woman's Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood

(Reference Committee "H")

At its July 1974 meeting the Board of Trustees approved the proposed program of the Woman's Auxiliary for 1974-75 as submitted. There was no need for a formal meeting of this Committee during the course of the administrative year.

Recognizing the need for support and action of the Woman's Auxiliary in the field of legislation, the Board asked that the Auxiliary Legislation Chairman sit in on the meetings of the Council on Legislation. She has reported to her Board and requested action when needed.

A member of the Woman's Auxiliary has been appointed to serve as a liaison for the Board of the College of Medicine and Dentistry of New Jersey.

This year the Auxiliary has stressed involvement in community service by the following means:

1. Health seminars for the public and for those in the health professions
2. Eye-screening programs
3. Volunteer work in county and state hospitals

Top priority has been given to raising funds for the Medical Student Loan Fund of MSNJ and for the AMA-ERF. Other fund raising has provided health career scholarships on the county level.

Filed (page Tr 128)



Mrs. Brennan — President, Woman's Auxiliary



Dr. Todd (AMA), Mrs. Brennan, Dr. Rogers

Administrative Council

Legislation

Meyer L. Abrams, M.D., Chairman, Cherry Hill

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society in the 1974-75 Legislature.

The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings.

Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's Official Intermediaries with New Jersey Specialty Societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society it be a standing policy to invite the chairman of each Council and standing committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative.

The Board of Trustees appointed an Ad Hoc Committee to study and redefine the role and function of the Council on Legislation. The Ad Hoc Committee met on November 24, 1974 and the following report was submitted and approved by the Board of Trustees at its December 15, 1974, meeting:

1. Soft dollar administrative assistance to JEMPAC.
2. Liaison members of MSNJ becoming members of the Executive Committee of JEMPAC.
3. Membership and leadership begins at the top, therefore, it is urged that members of the Board of Trustees have membership in JEMPAC.
4. The legislative arm of the Woman's Auxiliary be used more actively.
5. JEMPAC reports being presented to the Council on Legislation.
6. That the Emergency Action Committee be utilized whenever practical and possible and consider contacting specific members of the specialty societies of any legislation affecting their specific society.

CURRENT STATE LEGISLATION

In the afternoon of January 14, 1975, the Second Annual Session (1975) of the 196th New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members. The Senate is presently made up of 10 Republicans, 29 Democrats, and 1 Independent. The Assembly has a total of 80 members of whom 15 are Republicans and 63 are Democrats. Two seats in the Assembly are currently vacant. By means of official legislative bulletins the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as component societies, cooperating agencies, county keymen, and county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

ACTIVE SUPPORT All-out support for the measure

ACTIVE OPPOSITION All-out opposition for the measure

APPROVAL Commended as satisfactory, but not actively supported

CONDITIONAL APPROVAL To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out

DISAPPROVAL Rejected as unsatisfactory, but not actively opposed

NO ACTION Considered, but not regarded as significant or relevant to the proper interest of the Society

- S-546 — To provide that any condition of impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis, shall be deemed to be an occupational disease. *DISAPPROVED*, because this bill involves diagnosis by a legislative enactment rather than by medical investigation.
- S-971 — To provide that a teaching staff member shall not be required to disclose information received from a pupil which concerns alcohol or drug abuse. *NO ACTION*
- S-1032 — To establish a Mental Treatment Standards Committee and Patient Treatment Review Board in the Department of Institutions and Agencies. *APPROVED*
- S-1033 — To provide for the employment of patients in facilities for the mentally ill and in State and county residential services for the mentally retarded. *APPROVED*
- S-1034 — To provide that the Department of Institutions and Agencies shall establish a method for determining ability to pay for services for the mentally ill and the commitment of the mentally ill and to provide that the Department in cooperation with the county adjuster shall arrange for commitment hearings. *APPROVED*
- S-1074 — To establish a Department of Mental Health in the Executive branch of government. *APPROVED*
- S-1084 — To regulate the practice of dentistry and dental hygiene. *APPROVED*
- S-1094 — To repeal R.S. 45:12A-11 concerning performance of orthoptic services in a hospital. *APPROVED*
- S-1115 — To provide for a new definition of criminal responsibility to replace the McNaughton test and to provide for the disposition of those persons criminally irresponsible. *APPROVED*
- S-1167 — To include nursing homes and convalescent homes as health care facilities. *NO ACTION*
- S-1201 — To permit employers engaged in the manufacture, delivery, distribution, transportation of controlled dangerous substances or any firearm to require lie detector tests of their employees. *NO ACTION*
- S-1220 — To require separation of newspapers from other waste for collection and to authorize the Commissioner of Environmental Protection to prescribe standards for storage and disposal of solid waste for recycling, reprocessing and recovery of newspapers. *NO ACTION*
- S-1226 — To permit the courts to require medical or psychiatric treatment or term of imprisonment of up to 3 months for a second offense for operating a motor vehicle while under the influence of alcohol. *APPROVED*
- S-1233 — To bring the Medical Assistance and Health Services Act into conformity with changes necessitated by the State take-over of administration of public assistance programs. *APPROVED*
- S-1248 — To exclude State owned or controlled facilities from the coverage of the Health Care Facilities Financing Authority Law. *APPROVED*
- S-1284 — To create a commission to study and evaluate the State's institutions, agencies, and services for the mentally ill and to appropriate \$25,000. *DISAPPROVED*, because an existing study is currently under way.
- S-1288 — To provide that any duly incorporated association, organization, league, society, or other group created for the purpose of protecting dumb animals shall have the same rights, powers, and privileges as are vested in the New Jersey Society for Prevention of Cruelty to Animals. *DISAPPROVED*, because there is no evidence that existing statutes protecting dumb animals from cruelty are now being flagrantly violated or that the SPCA has failed — or is failing — to perform its responsibilities in enforcing those laws.
- S-1310 — To authorize the Commissioner of Institutions and Agencies to participate with the United States Secretary of Health, Education, and Welfare in waiving medicaid eligibility requirements and to provide benefits to individuals or groups for whom Federal funding could not be obtained and to delete "under general policies established by the State Board of Control." *NO ACTION*. LAW 1974, Chapter 140.
- S-1320 — To provide that the procuring, furnishing, donating, processing, and distributing of human organs shall not give rise to any implied warranty and the doctrine of strict tort liability shall not be applicable in any civil action brought in connection therewith. *ACTIVE SUPPORT*
- S-1326 — To provide for the rehabilitation or liquidation of impaired or insolvent insurers. *NO ACTION*
- S-1373 — To appropriate \$5,000 to the Commission to Study Drug Laws, Penalties and Treatment Programs in contemplation of beginning research into its second report. *NO ACTION*
- S-1387 — To permit patients in nursing or convalescent homes to obtain drugs from a source other than said home. *APPROVED*
- S-1392 — To supplement the "Medical and Dental Education Act of 1970." *NO ACTION*
- S-1421 — To authorize counties and municipalities to make appropriations to organizations for emotionally or physically undernourished children. *APPROVED*
- S-1422 — To regulate referrals to health care facilities. *APPROVED*
- S-1438 — To appropriate \$500,000 to the Department of Health for hemophilia purposes. *APPROVED*
- S-1442 — To exempt registered pharmacists 65 years of age

- or older from the requirements of the "Continuing Pharmaceutical Education Act." *DISAPPROVED*, because anyone actively involved in dispensing medication or treatment must be current in the practice of their profession.
- S-1461 — To reduce penalties for possession and use of small amounts of marihuana and hashish. *NO ACTION*
- A-1529 — To provide that no person having jurisdiction over potable water shall direct mandatory fluoridation until the question has been first approved by voters in a referendum. *DISAPPROVED*, because MSNJ is in favor of mandatory fluoridation as a public health measure.
- A-1543 — To prescribe what is a justifiable abortion and to permit physicians, medical personnel and private institutions to refuse to perform an abortion. *APPROVED*
- A-1551 — To prohibit podiatrists, optometrists or psychologists from charging patients an extra fee for completing a medical claim form for health insurance. *NO ACTION*
- A-1552 — To require physicians to obtain professional liability insurance with minimum coverage of \$100,000 as a prerequisite to being licensed. *DISAPPROVED*, because there is no guarantee that a physician could get insurance and the lack of said insurance should not, in any way, put his license in jeopardy, also the bill would be a deterrent to any physician considering residency in New Jersey. The legislation is restrictive, impractical and has no bearing on the qualifications of the physician.
- A-1618 — To require itemization and verification of medical bills, ban contingent fee arrangements and limit two-tier billing by physicians and surgeons. *APPROVED*
- A-1619 — To provide that any person who knowingly employs an unlicensed x-ray technician shall be guilty of a misdemeanor. *ACTION DEFERRED* pending further study by the Council on Legislation
- A-1620 — To provide that it shall be a misdemeanor for any physician or surgeon to intentionally falsify any medical report used in workmen's compensation, negligence cases or any other type of legal proceeding. *APPROVED*
- A-1632 — To provide for health insurance for seasonal farmworkers. *NO ACTION*
- A-1681 — To define conditions under which optometrists shall advise patients to confer with an ophthalmologist. *ACTION DEFERRED*, pending a report of the special ad hoc committee, consisting of an internist, a member of the Council on Legislation and a representative of the Academy of Ophthalmology and Otolaryngology chosen to redraft this legislation or properly amend it.
- A-1703 — To permit employees of municipal institutions holding the degree of M.D. or D.O. to apply to the Board of Medical Examiners for exemption from the act concerning the practice of medicine and surgery. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.
- A-1710 — To redefine various terms with respect to the practice of nursing. *NO ACTION*
- A-1727 — To require medical facilities, public or private schools, state, county, or municipal health and welfare departments, higher education medical facility or other instrumentality to make available birth control information, family planning services and medically acceptable contraceptives and permits refusal to provide such information without being held liable for refusal. *DISAPPROVED*, because the cooperation of parents and educators should be voluntarily encouraged rather than mandated.
- A-1734 — To give minors access to birth control or contraceptive procedures and to prohibit permanent sterilization procedures without the consent of the parent or guardian. *APPROVED*
- A-1760 — To increase to \$10,000 from \$5,000 the amount of money freeholders may appropriate for children afflicted with sickle cell anemia. *APPROVED*
- A-1767 — To prohibit practitioners from dispensing methadone without approval of the Commissioner of Health after first informing him of the name of the individual to be treated and amount of methadone to be dispensed. *DISAPPROVED*, because the purpose of this bill is already superseded by Federal Legislation.
- A-1770 — To require the Commissioner of Health to issue a Sanitary Inspector 2nd Grade license to any person who has experience as a sanitary inspector, has a required Public Health certificate, plus a certificate in water purification notwithstanding he has not completed a formal course in biology or physical science. *DISAPPROVED*, because this bill lowers the standards of public health.
- A-1780 — To prohibit smoking in any hospital patient room or patient area, elevator, indoor theater, library, art museum, concert hall, school building, school athletic facility or bus except in areas designated as smoking areas. *NO ACTION*
- A-1786 — To require health care facilities to designate not less than 30% nor more than 50% of the total number of patient rooms as "No Smoking Allowed" rooms. *DISAPPROVED*, because such a system would present burdensome administrative problems for health facilities.
- A-1792 — To provide that no new solid waste facility shall be constructed within 1,000 feet of any residence; to require inspections of every solid waste facility by the Department of Environmental Protection at least 4 times a year and to appropriate \$50,000 for hiring inspecting personnel. *NO ACTION*

- A-1914 — To lower the age requirement for the education of handicapped children from 5 to 3 years of age. *APPROVED*
- A-1919 — To provide transportation for handicapped children going to and from any remote school other than a public school, except a school operated for profit, located in the State not more than 20 miles from the residence of the child. *APPROVED*
- A-1952 — To require the inclusion of treatment for alcoholism in all group health, medical, and hospitalization insurance plans issued or renewed in New Jersey. *APPROVED*
- A-2023 — To amend the "New Jersey Medical Assistance and Health Services Act." *NO ACTION*
- A-2060 — Imposes the sales tax on all professional services. *DISAPPROVED, ACTIVE OPPOSITION, IF THE BILL MOVES*, because the passage of this bill would sharply increase the cost of medical care.
- A-2112 — To remove the licensing requirement for ophthalmic technicians. *APPROVED*
- A-2123 — To extend the implied consent law concerning motor vehicle violations to the taking of urine and blood samples to determine if the operator of a motor vehicle is under the influence of controlled dangerous substances. *APPROVED*
- A-2158 — To permit employment on a salary basis by municipal hospitals of physicians who do not hold New Jersey licenses. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.
- A-2160 — To require law enforcement officers, when arresting a person not in control of his physical functions, to determine whether the person is wearing a medical alert device specifically delineating a medical disability and to require immediate medical aid. *APPROVED*
- A-2172 — To exempt hypodermic needles and syringes sold pursuant to a doctor's prescription from the Sales and Use Tax Act. *APPROVED*
- A-2205 — To prohibit a physician or surgeon to enter into a contingent fee arrangement in any matter where medical treatment or services are rendered to form any basis of a legal claim for damages or workmen's compensation. *APPROVED*
- A-2206 — To require insurance companies to file a report with the Secretary of State of amounts paid to physicians and to provide for penalties. *NO ACTION*
- A-2207 — To provide that it shall be a misdemeanor for a physician to charge fees excessively higher than the normal patient fees for services in workmen's compensation or negligence action claims. *APPROVED*
- A-2209 — To provide that it shall be a misdemeanor for any physician or surgeon to execute a false medical report which is subsequently submitted to any judicial or administrative proceeding. *APPROVED*
- A-2210 — To require physicians and surgeons to provide patients with a true, accurate and itemized copy of the bill for treatment rendered where it will be the basis of a legal claim for workmen's compensation or damages in negligence. *NO ACTION*
- A-2234 — To increase the amount of the fine which may be imposed in convictions for drunken and impaired driving. *NO ACTION*
- A-2246 — To require that privately owned buildings, open to the public, have proper access and facilities for the handicapped. *NO ACTION*
- A-2247 — To provide medical study scholarships for students agreeing to practice medicine in areas designated as having a shortage of physicians. *APPROVED*
- A-2259 — To provide immunity to civil defense units, volunteer fire companies, volunteer first aid, rescue or emergency squads from liability in any civil action to respond in damages for any acts arising out of services. *APPROVED*
- A-2285 — To appropriate \$500,000 to the Department of Health for the treatment of hemophilia. *APPROVED*
- A-2301 — To require every restaurant and temporary retail food establishment to have a Department of Health approved device upon the premises intended for use in removing food which becomes lodged in a person's throat. *DISAPPROVED*, because there are alternate methods for this procedure, other than the use of surgical instruments.
- A-2329 — To provide for annual licensure of all clinical laboratories based on demonstrated ability to meet standards of performance of services offered which are accepted and approved by the Department of Health and to initiate a program of education and training, to appropriate \$150,000. *DISAPPROVED*, because of recent amendment to the law (Dec. 18, 1973).
- A-2347 — To permit a municipality to contribute \$25,000 to first aid and/or emergency or volunteer ambulance or rescue squads. *APPROVED*

FEDERAL LEGISLATION

The National Health Resources Planning and Development Act, opposed by the AMA and The Medical Society of New Jersey, was signed into Law by President Ford in January 1975. This Act merged Certificate of Need, Hill-Burton, Regional Medical, Medicare and Medicaid, and several other Federal Laws into a single administrative office within HEW.

Superseding all previous planning acts it granted the Secretary of HEW czarist power and the Secretary acted accordingly. Declaring that exceptions to his Health Service Area designations might be considered but probably would not be accepted, the Secretary then ceded Bergen County to New York City; Warren County to Easton, Pennsylvania; Burlington, Camden, and Gloucester Counties to Philadelphia; and Salem County to Wilmington, Delaware.

Meanwhile the program which has a projected budget of 10 billion dollars and a Fall implementation date has not been funded.

Currently the argument over National Health Insurance remains at a stalemate with at least 15 different versions under consideration.

The issue of professional liability insurance has also drawn Federal attention. Five of the six legislative proposals are opposed by the AMA. The favored bill, calling for a realistic study and state by state legislation, has AMA approval.

Filed with notation (page Tr 121)

Supplemental Report #1

At its meeting in May, the Board of Trustees considered and acted upon recommendations from the Council's meeting of April 17. The Council therefore offers this Supplemental Report covering items dealt with since the compilation of its annual report.

MALPRACTICE INSURANCE

A-1552—An act concerning medical malpractice liability insurance, requiring certain licensed medical practitioners and health care facilities to maintain such insurance, and creating a New Jersey Medical Malpractice Reinsurance Association, a New Jersey Medical Malpractice Reinsurance Recovery Fund and a New Jersey Health Care Facility Insurance Deductible Fund. *ACTIVE OPPOSITION*, because this bill attempts to apply a theory of casualty insurance to professional liability which is entirely incompatible with logic, reason, and insurance factors. Additionally, there is no "availability" crisis in New Jersey so that the only effect of this bill would be increased cost and destruction of the current market.

Note: Amendments attached to this bill in late February changed its intent and scope to create a state con-

trolled insurance facility. The position on this bill was subsequently changed from *DISAPPROVED* (as previously reported) to *ACTIVE OPPOSITION* by the Board of Trustees following the report of the Committee on Medical Defense and Insurance.

CURRENT STATE LEGISLATION

The following list presents the official position of The Medical Society of New Jersey regarding additional bills currently in the Legislature:

S-130 —Designated the "Local Health Services Act," provides for modern public health services in all municipalities. *ACTION DEFERRED*, pending further information from the Council on Public Health.

S-350 —To require psychological examinations before persons are appointed to a police department. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the psychological examination is conducted under the supervision of a psychiatrist.

S-1077—To require prescription blanks for prescriptions for controlled dangerous substances to be serially numbered with the name of the prescriber printed immediately preceding the number. *DISAPPROVED*, because this bill, due to a lack of an enforceable system of accountability, would be impossible of implementation.

S-1117—To delineate the basic rights of persons confined because of mental illness or retardation. *NO ACTION*

S-1118—To provide for individual attention to patients confined for mental illness and to establish a judicial review for persons confined beyond 31 days and to provide for legal counsel. *APPROVED*

S-1119—To direct the Department of Institutions and Agencies to provide for the establishment of emergency mental health services. *DISAPPROVED*, because the wording of certain sections of this bill will prevent it from achieving the goals which all humane persons deem desirable. It therefore requires further study and amendment.

S-1127—To provide for the establishment of medical and dental education programs by the College of Medicine and Dentistry of New Jersey. *APPROVED*

S-1210—To provide for licensing of social workers. *DISAPPROVED*, because the bill would permit social workers to use medical modalities and therapeutics when they do not have the training, education, or experience to function in such a capacity.

S-1214—To amend and supplement the act providing for registration of physical therapists. *CONDITIONAL APPROVAL*, subject to amendments deleting the use of diagnostic electromyography and inserting the requirement that physical therapy services be rendered at the specific direction or

prescription of a plenary licensed physician or surgeon.

- S-1306*—To provide that it shall be unlawful to sell any living or dead human fetus or for any person to purchase, acquire or use such fetus for experimental, research, or transplant purposes. *DISAPPROVED*, because it would make donations pursuant to the Uniform Anatomical Gift Act unlawful.
- S-1407*—To provide for the involuntary commitment of persons believed to be mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-1428*—To regulate long term health care facilities licensed under the Health Care Facilities Planning Act. *NO ACTION*
- S-1483*—To authorize the expenditure of funds for the establishment and maintenance of eye bank facilities and to appropriate \$25,000 for entering into agreements with the New Jersey Eye Bank at the Newark City Hospital. *APPROVED*
- S-1515*—To provide for the examination of pupils and amending New Jersey Statutes 18A:40-4. *APPROVED*
- S-1517*—To require county mental health boards to create the position of mental health administrator. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-1523*—To prohibit the addition of fluorides to any municipal water supply where total fluorides from all sources in the environment exceed an average of 1.2 milligrams per day per person and to require the Department of Environmental Protection to survey all areas of the State for environmental fluoride content. *APPROVED*
- S-1528*—To establish a Drug Utilization Review Council which shall prepare a list of interchangeable drug products and to provide that no drug shall be included in the list until after a public hearing. *ACTIVE OPPOSITION*, because this bill would pre-empt the right of a physician to practice medicine in the manner in which he has been trained and wishes to do for the greatest benefit to the patients' well being and equality. Further, there is no procedure available at this time to guarantee bioavailability or equivalency. There has not been a proper establishment of liability for malpractice in the transfer of responsibility when substituted generic equivalents are implemented. The use of non-professionals on the proposed drug council would jeopardize the selection of proper medication.
- S-1540*—To provide for the establishment of a South Jersey branch of the College of Medicine and Dentistry to be ready to admit candidates for degrees in the Fall of 1976; to appropriate \$50,000. *ACTIVE SUPPORT* Law, c.66 ('75)
- S-3002*—To require every school or commercial bus transporting children to be equipped with seat belts or other restraint systems for each passenger and the driver. *APPROVED*
- S-3017*—To provide that no health care facility shall be operated unless it shall, in the case of skilled and intermediate care nursing facilities, establish and maintain a system of discharge planning which assures every patient a planned program of continuing care which meets his post-discharge needs. *NO ACTION*
- S-3025*—To include residential health care facility under the Health Care Facilities Planning Act and to direct the Commissioner of Health in consultation with the Commissioner of Institutions and Agencies to annually establish a per diem rate of compensation to be paid to public guests of residential health care facilities. *ACTION DEFERRED*, pending a conference with the sponsors.
- S-3035*—To require hospital service corporations to offer home health care coverages. *ACTION DEFERRED*, pending further information from Medical-Surgical Plan of New Jersey.
- S-3040*—To require the use of specified generic drugs in New Jersey's Medicaid Program, to establish a Drug Advisory Council and to appropriate \$50,000. *ACTIVE OPPOSITION*, because this bill would force the use of a substituted generic equivalent drug when there is no procedure available at this time to guarantee bioavailability or equivalency between substituted products. It would discriminate against a segment of the population by possibly legislating inferior medical treatment to that group.
- S-3043*—To provide that no health care facility intended to be used for or in any way applied to the conduct of abortions shall be operated in any municipality unless a referendum on the question is held at a general election. *DISAPPROVED*, because this bill would discriminate against women desiring abortions and would force them to seek services outside of their community. Additionally, the constitutionality of such a statute is suspect in view of U.S. Supreme Court decisions on this topic.
- S-3060*—To provide that no health care facility intended to be operated as an outpatient abortion facility shall receive a certificate of need unless it can be clearly demonstrated that the outpatient facility has a written affiliation with one or more hospitals, that there is a procedure for transmitting pertinent clinical information to the hospital and that there is immediately available transportation. *APPROVED*
- S-3085*—To provide for establishing county boards of health in every county under a "County Environmental Health Act." *APPROVED*
- S-3098*—To provide for the licensing of audiologists and speech pathologists by the Board of Medical Examiners. *DISAPPROVED*, because the bill does not provide that the audiologist is to function at the direction or prescription of a duly licensed physician, a factor which is necessary for sound health care, plus, it is questionable whether licensing would serve any useful purpose.
- S-3122*—To require testing of newborn infants for hearing impairments. *ACTION DEFERRED*, pending further information from the Department of Health.

- S-3128—To provide for the establishment of a hereditary disorders program. *ACTION DEFERRED*, pending a copy of the bill.
- A-588 —To provide for an examination of members of the police department before appointment thereto by a licensed practicing psychologist or psychiatrist. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the psychological examination is conducted under the supervision of a psychiatrist.
- A-1583—To require health care facilities to provide information to persons who need such for obtaining health insurance or receipt of health insurance benefits. *ACTION DEFERRED*, pending a conference with the sponsors of the bill.
- A-1619—To provide that any person who knowingly employs an unlicensed x-ray technician shall be guilty of a misdemeanor. *APPROVED*
- A-1681—To define conditions under which optometrists shall advise patients to confer with an ophthalmologist. *CONDITIONAL APPROVAL*, provided that suggested amendments are made to the bill.
- A-1690—To define "Services" in the Retail Installment Sales Act to include work, labor, and services, "professional and otherwise." *NO ACTION*
- A-2086—To establish qualifications for laboratory directors under the Bio-Analytical Laboratory and Laboratory Directors Act in conformity with the Federal standards for such directors in Title 20, Chapter 3, Part 405 of the code of Federal Regulations. *DISAPPROVED*, because this bill would lower the standards of existing statutes and would impose a costly regulation system in lieu of the high quality system already adopted in 44 other states.
- A-2208—To provide that it shall be a misdemeanor to employ an unlicensed x-ray technician. *APPROVED*
- A-2313—To permit the Board of Higher Education to award not more than \$6,000 per annum per student to all accredited schools of veterinary medicine which accept New Jersey residents in their degree programs. *APPROVED*
- A-2324—To require employers to have a first aid kit as prescribed by the Commissioner of Health readily accessible for the treatment of injured persons. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the contents of the kit should be determined by a qualified physician.
- A-2405—To amend and supplement the act concerning physical therapists defining "physiotherapy," "physical therapist," and "physical therapist assistant," to require a minimum academic standard. *CONDITIONAL APPROVAL*, subject to amendments deleting the use of diagnostic electromyography and inserting the requirement that physical therapy services be rendered at the specific direction or prescription of a plenary licensed physician or surgeon.
- A-3042—To authorize the Commissioner of Insurance to review and approve the format and provisions of all insurance policies issued by any insurer authorized to do business in this State. *NO ACTION*
- A-3051—To provide for the licensing and registration of the practice of massage and to create a Board of Massage Examiners. *DISAPPROVED*, because this bill is not of legitimate licensing interest and, further, would authorize chiropractors to prescribe a modality which is outside the scope of their license.
- A-3087—To establish a program of pharmaceutical assistance to persons 65 years of age and over who earn less than \$6,000 per year. *APPROVED*
- A-3093—To provide for the Department of Mental Hygiene Act. *DISAPPROVED*, in favor of S-1074.
- A-3094—To create a New Jersey Medical Malpractice Reinsurance Association, Recovery Fund and Deductible Fund. *ACTIVE OPPOSITION*, because this bill attempts to apply a theory of casualty insurance to professional liability which is entirely incompatible with logic, reason, and insurance factors. Additionally, there is no "availability" crisis in New Jersey so that the only effect of this bill would be increased cost and destruction of the current market.
- A-3109—To declare it the public policy of the State to encourage the development of community mental health programs in order to minimize the need for admissions and readmissions to State and county hospitals. *APPROVED*
- A-3116—To provide that no health care facility which is intended to be used or applied to the conduct of abortions shall be operated in any municipality unless a referendum on the question is held at a general election. *DISAPPROVED*, because this bill would discriminate against women desiring abortions and would force them to seek services outside of their community. Additionally, the constitutionality of such a statute is suspect in view of U.S. Supreme Court decisions on this topic.
- A-3123—To provide that any employer shall not be liable for continuing treatment under the workmen's compensation law, included but not limited to physical therapy, chiropractic, neurological and neuropsychiatric treatment, unless the employee has obtained a court order for the treatment on formal motion before a judge of compensation, beyond what an employer or carrier will authorize. *DISAPPROVED*, while the principle behind this bill is desirable the method employed would result in a disservice to the injured and ill worker and would act as a deterrent to prompt diagnosis and treatment. A more favorable approach would be to require the employer to secure an order terminating treatment or declaring further treatment uncompensable.
- A-3154—To provide that no health care facility intended to be operated as an outpatient abortion facility shall receive a certificate of need unless it can be clearly demonstrated that the outpatient facility

has a written affiliation with one or more hospitals, that there is a procedure for transmitting pertinent clinical information to the hospital and that there is immediately available transportation. *APPROVED*

A-3214—To provide for issuance of identification cards and health certificates to minors over age 12 years for use in obtaining employment. *APPROVED*

A-3236—To require drivers' licenses to contain a space where a sticker will show that he has made a gift of part of his body under the Uniform Anatomical Gifts act. *APPROVED*

A-3287—To exempt volunteer, first aid, rescue and ambulance squads from the provisions of the Health Care Facilities Planning Act. *APPROVED*

Filed (page Tr 121)

Supplemental Report #2

At its meeting on May 18, the Board of Trustees considered and acted upon the following bills presently in the New Jersey Legislature.

S-3161 — To amend the definition of podiatry to delete the restriction against major surgery and to embrace the entire foot. *ACTIVE OPPOSITION*, because it would permit podiatrists to perform procedures and utilize modalities for which they are not adequately trained.

S-3162 — To permit issuance of limited certificates for x-ray technicians in foot radiology. *ACTION DEFERRED*, pending consultation with representatives of the New Jersey Chapter of the American College of Radiology. Final action to be made by the Emergency Action Committee of the Council on Legislation.

S-3163 — To grant immunity from suit to members of peer review committees when acting in good faith in the scope of their function. *APPROVED*

S-3164 — To provide that graduates of accelerated courses in approved colleges of podiatry shall be eligible for licensure in New Jersey. *DISAPPROVED*, because it is evident that accelerated courses have not been as successful as originally planned.

A-3263 — To permit optometrists to advertise and to practice in retail or commercial settings. (Hearing scheduled for May 22, at 10:00 a.m., at Seton Hall University School of Law-Newark.) *ACTIVE OPPOSITION*, since it would commercialize health-care services and increase costs.

A-3273 — To permit advertising of retail prices of prescription drugs and to require pharmacy posting of prices of commonly dispensed prescription drugs. *CONDITIONAL APPROVAL*, providing the portion on advertising is deleted.

Filed (page Tr 121)



President Rogers

Speaker of the House Mineur

AMA President Todd

Administrative Council

Medical Services

Robert E. Fullilove, Jr., M.D., Chairman, Newark

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of standards and character of medical practices in New Jersey, and the investigation of the economic and social aspects of medical care.

AD HOC COMMITTEE ON NUTRITION

This Committee was formulated with direction from the AMA Council on Nutrition. Dr. Howard Jacobson was appointed Chairman of this *ad hoc* committee which will work in three areas: nutrition guidelines for accreditation of hospitals for training of interns and residents; nutrition guidelines for the use of agencies assessing health services through agencies such as PSRO's, HMO's, nursing homes, and so on; and, finally, there is a concern for the direction being taken in food services — convenience foods, contract services, and so on — wherein responsibility for proper training, counseling, and production rest.

The Council looks forward to this Committee's findings and recommendations.

MEDICALLY INDICATED ABORTION REIMBURSEMENT

The Council considered Resolution #38 adopted by the 1974 House of Delegates which states that MSNJ actively support the right of all pregnant women to receive third party reimbursement for abortions, that the Council on Medical Services draft a position statement on same. The position statement has been formulated and approved by the Council. This position statement has been sent to the Office of Medicaid for their consideration.

ADOPTION OF AMA GUIDELINES FOR PHYSICIAN- HOSPITAL RELATIONSHIPS

The AMA has guidelines for code of procedures for medical services, physician-hospital relationships, to be adopted for New Jersey.

These guidelines are to be utilized by every hospital, medical and administrative staff. These guidelines have been approved by the Council members.

REQUEST OF NEW JERSEY STATE COMMISSION OF INVESTIGATION CONCERNING PHYSICIAN ABUSES IN COMPENSATION AND NEGLIGENCE CASES

The Board of Trustees referred to this Council a formulation of guidelines to avoid physician abuse in compensation and negligence cases. The Council considered the request and recognizes the need for guidelines. The Council referred this to the Special Committee on Occupational Health, Workmen's Compensation and Rehabilitation for the formulation of guidelines and report back to the Council.

PRIMARY PEER REVIEW BY THIRD PARTIES

Resolution #23 adopted by the 1974 House of Delegates reads that third party payors, e.g., Blue Shield, Medicare, and so on, are practicing medicine by computer or clerk. This item was referred to MSNJ's Permanent Committee on Blue Cross-Blue Shield and also the Health Insurance Conference for their investigation and report back to Council.

PAYMENT BY BLUE SHIELD FOR MEDICAL CONSULTATION IN CONSULTANT'S OFFICE (RESOLUTION #11) AND REHABILITATION COVERAGE (RESOLUTION #12)

Resolutions # 11 and #12, which deal with reimbursable medical services of the Medical Service Plan of New Jersey, were referred by the 1974 House of Delegates for consideration by the Council. The Council was informed that there are riders for both of these services. The Council agreed these items should be part of the basic health program. MSNJ's Permanent Committee on Blue Cross-Blue Shield and the Consumer Affairs Committee of the Blue Shield

Corporation have been requested by this Council to give consideration to these two items.

Filed with notation (page Tr 124)

Supplemental Report

MEMBERSHIP INQUIRIES AND COMPLAINT COMMITTEES

Joseph C. Lucci, Executive Assistant
(Reference Committee "F")

Inquiries and Complaints Aug. 1, 1974 to May 1, 1975:

Medicare

Seven complaints were received from seven physicians. This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. There are no complaints pending.

Medicaid

Eight complaints were received from eight physicians. This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. Three complaints are pending.

Medical-Surgical Plan of New Jersey

Two complaints were received from two physicians. This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. There are no complaints pending.

Other Health Insurance Carriers

Three complaints were received from two physicians. This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. One complaint is pending.

Filed (page Tr 124)

Special Committee to Council on Medical Services **Occupational Health, Workmen's Compensation, and Rehabilitation**

Elmer J. Elias, M.D., Chairman, Trenton

(Reference Committee "F")

The Board of Trustees referred to this Committee the "Report of the New Jersey Workmen's Compensation Study Commission" for evaluation. Since this report has been published, several bills have been introduced into the legislature concerning workmen's compensation. The Committee will consider this report and all pertinent bills in order to come up with proper interpretation for legislation.

Also, the Committee was directed by the Council on Medical Services to explore, through the Division of Vocational Rehabilitation Services, the possibility of coverage for rehabilitation services for those who are not participants of either Medicare or Medicaid and are only covered by Blue Cross.

Filed (page Tr 124)

Administrative Council

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

At the time of preparation, three meetings of the Council have been held; the fourth is scheduled to take place one week before the deadline for submission of this report.

The Council continues to experience disappointment in the attendance records of certain members of its special committees. Despite new blood from the hearty cooperation of the President and Executive Director of The Medical Society of New Jersey, we continue to find that the chairmen of some committees are tremendously handicapped by absent members. This is particularly true of the Special Committee on Emotional Disorders of Childhood and Adolescence and the Special Committee on Mental Retardation. We are of the opinion that these Committees should be abandoned unless a reverse trend of interest can be created. The individual accomplishments of these Special Committees are reported elsewhere.

The Council primarily busied itself with the following old items of business:

(1) *School for Professional Psychology* — Having failed in its efforts to defeat the creation of this school at Rutgers, we are endeavoring to implement a concentrated educational effort to prevent the erosion of quality medical care of the residents of New Jersey. We believe it is one of the obligations of The Medical Society of New Jersey to pursue this cause. Hopefully this will be accomplished *via* public informational releases, and State administration information.

(2) *The Sick Physician* — This matter is being handled *via* a small ad hoc committee in drafting guidelines which were forwarded to the Board of Trustees. We understand that the State Board of Medical Examiners has drafted legislation, and

we will await its appearance for study and review.

Referrals from Council on Legislation Regarding Mental Health — An extraordinary number of bills regarding the issue of mental health and/or related topics have been brought to our attention. We appointed one of our members as liaison to the Council on Legislation and he has performed in a yeoman-like fashion. Although many of these proposals were of major interest to us, probably the most comprehensive yet controversial is S-1119 because of its many far-reaching efforts. Even though we favor the concept and intent, we recommend disapproval in its present form.

Among new items of business dealt with during this ensuing year (which are not yet finalized for recommendation to the Board of Trustees and which will probably be carried over) are the following:

- (1) Abolition of AMA Council on Mental Health
- (2) Clinical Research for Mental Illness
- (3) Involuntary Commitments
- (4) Statewide Congress on Mental Health, including: (a) Anti-hospital and anti-psychiatry campaigns, (b) Civil Liberties Attacks, (c) Right to Treatment, and (d) Abolition of Public Mental Hospitals
- (5) Education Regarding Genetic Factors
- (6) MSNJ Exhibit at APA Annual Meeting, May 1976, in Atlantic City.

Appropriate pursuit of any of these will occupy subsequent Council meeting agendas to the fullest extent.

Filed (page Tr 124)

Special Committees to Council on Mental Health

Alcoholism

Robert S. Albahary, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Special Committee on Alcoholism met regularly and discussed various problems connected with care of alcoholic patients in the State of New Jersey.

DRINKING — DRIVING STANDARDS

The Committee stated that they are in full agreement with the recommendations of the Alcohol Countermeasures Project of the Division of Motor Vehicles. These recommendations are to become a part of the anticipated legislation which the Division is formulating. These recommendations will be fully reviewed by this Committee.

ALCOHOLISM PROGRAM — NEW JERSEY DEPARTMENT OF HEALTH

Mr. William Ramsey of the Alcoholism Program, New Jersey State Department of

Health, was invited to update the Committee in the field of alcoholism control. He indicated that the two major interests of his program will be setting up detoxification units and the development of half-way houses throughout the State. There was also some discussion about the growing problem of the teenage alcoholic. In the older alcoholic, the attitude is more cooperative than in the younger group. The attitude of the teenage alcoholic is totally different. Discipline is a real problem. It was noted that alcoholism in the younger age group has been steadily increasing and has become a problem of real concern.

This Committee will look into these problems in order to cooperate fully with the Department of Health.

Filed (page Tr 124)

Drug Abuse

Laura E. Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

The 435-page report, Comprehensive Drug Abuse Prevention Plan, State of New Jersey — 1973, prepared by the New Jersey State Department of Health, Division of Narcotic and Drug Abuse Control, Trenton, New Jersey, was carefully reviewed by all members of the Committee. Although a tremendous amount of material is covered in this volume, it was the opinion of the Committee that no statistical studies to date are truly accurate reflections of the problem of drug abuse in this State because New Jersey is a corridor between Philadelphia and New York City. Incidentally, the highly populated counties adjacent to these two cities have the largest number of drug abusers.

Letters were mailed to each county medical society's Committee on Drug Abuse, questioning them as to their activities for the past two years. Of those counties responding, only Hudson and Essex counties are active in the field. Follow-up letters were sent to those counties that are nonactive urging that some activity be established in the field of drug abuse control.

The needs in prevention and treatment of addiction were felt to be multifaceted. This combined attack should involve the entire public, especially police, pharmacists, teachers, physicians, judges, lawyers, psychiatrists, psychologists, social workers and clergy. Because the

use of marijuana is a controversial topic and because of its social acceptance, the Committee feels removal of the legal penalties for possession of marijuana ought to be given consideration.

Mr. Richard J. Russo, Assistant Commissioner, Alcohol, Narcotic and Drug Abuse, of the State Department of Health, and Lieutenant William J. Kennedy of the New Jersey State Police attended the January 15, 1975 meeting of the Committee and described their methods for combating the drug problem. Much information and statistics were gathered from both.

The Medical Society of New Jersey distributed information on drug treatment centers: (1) to counties for further distribution; (2) to every member of the MSNJ as an insert to the March 1975 *Membership Newsletter*; and (3) as a giveaway at the Committee's exhibit at the 209th Annual Meeting.

The Committee re-emphasized the importance of patient confidentiality and the need for continual reinforcement of same both during and after treatment of any patient. Work is in progress in consultation with the Division of Narcotic and Drug Abuse Control to assure

patient/physician confidentiality as a part of our drug therapy.

The Committee presented an informational exhibit at the 209th Annual Meeting.

DESCRIPTION OF EXHIBIT

The center panel of the exhibit consisted of a large map of New Jersey and an indication of the location of all treatment centers. Listings of the locales of these centers were made available to be taken away for reference.

One panel contained the most recent figures available from the New Jersey Department of Health on "Narcotic and Drug Deaths Reported for 1972-1974 by Drug Category." Beneath this table was a plea to doctors to sign up for part-time work in treatment centers in their own locales. Forms for signing up were available.

The first panel emphasized the exhibit as the work of the Special Committee on Drug Abuse of The Medical Society of New Jersey. MSNJ's seal appeared on this panel, as well as a summary of morbidity and mortality statistics.

Filed (page to 124)

Emotional Disorders of Childhood and Adolescence

Joseph J. Kline, M.D., Chairman, Trenton

(Reference Committee "F")

The Committee met on two occasions during the year. It was necessary to alter the Committee's membership in order to obtain a quorum for its meetings.

The new directory entitled "Mental Health Services in New Jersey" was completed. The compilation and the distribution was a joint effort of the New Jersey Mental Health Association, Roche Laboratories, and this Committee. Copies of the directory have been sent to all New Jersey psychiatric hospitals, general hospitals, all agencies and hospitals listed in the directory, and to each county medical society. Copies of

the directory are available upon request by contacting MSNJ's Executive Offices.

The Committee anticipates that its major efforts in the coming year will be to disseminate information about the needs of the emotionally ill child and adolescent and the services available to them. Because of the profound effects of early neglect and abuse in a child's life, it is hoped that the organization of a speaker's bureau and the utilization of various communication media will help alert parents to early signs of emotional disorder, inform the citizenry of the services available to them, and stimulate hospital staffs

to include in their pre-natal and post-natal classes for the expectant mother instruction that will reduce the likelihood of emotional illness. The speaker's bureau is also envisioned as an educational tool to help mobilize the support of service organizations and other community

groups so that the critical and extensive needs of the disturbed child will be adequately met by his community and his state.

Filed (page Tr 124)

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

The Committee met three times the past year. A meeting with Mr. White and other representatives of Institutions and Agencies, the Department of Health, and the New Jersey Psychiatric Institute was held in February 1975. It was the opinion of all those present that a tertiary center for diagnosis and treatment of the mentally retarded should be established. This would best be located in the medical schools.

The final meeting of the Committee held in March 1975, ascertained that we should establish a metabolic center at the New Jersey Medical School under Dr. T. Kushnick, and the

Neurological Center at The Rutgers Medical School under Dr. L. Taft. This recommendation was made at the last meeting of the Council on Mental Health. It is recommended that the Medical Society endorse the concept of the two tertiary centers, to offer these services to the physicians of New Jersey.

We believe the Department of Institutions and Agencies will support these centers as they will also benefit greatly from these services.

Filed with notation (page Tr 125)

Neurological and Related Disorders

J. Lloyd Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

The Special Committee on Neurological and Related Disorders has actively pursued its scientific and public health purposes under the Council on Mental Health. The care of the spinal-cord-injured patient is still undergoing study by attempts to obtain an accurate estimate of the numbers of such patients and where facilities are most needed. Proper publicity has been given to multiple sclerosis in our State. We have concluded that L-dopa remains the drug of choice for Parkinsonism and hope for the early appearance of a new carboxylating drug to in-

crease its potency and effectiveness. We have responded to requests for aid and guidance in our area of expertise. Our original petition for a facility for the aged and infirm in apartment complexes has been returned to us for restudy. The Committee has expressed its displeasure with present day practices of involuntary commitment and joins with the Council on Mental Health in its efforts to obtain a practical solution of this problem.

Filed (page Tr 125)

Administrative Council

Public Health

Robert G. Salasin, M.D., Chairman, North Wildwood

(Reference Committee "G")

Many items reviewed this year by the Council were projects specifically assigned to the various subcommittees. Those items can be found within the reports of the Special Committees on Cancer Control; Chronically Ill and Aging; Child Health; Conservation of Vision, Hearing and Speech; Environmental Health; and Maternal and Infant Welfare.

The Board of Trustees, at its meeting of May 14, 1974, referred the following resolution to this Council: Resolution #25 — from the Salem County Medical Society — "Resolved, that this

Committee investigate and compile a list of various tissue banks and their locations to be available to physicians who may require various organs for surgical transplantation and others who wish to donate certain organs upon their demise."

Upon investigation by the Council, it was learned that the Executive Offices already have in existence such a list. This list will be updated and referred for publication in *The Journal*.

Filed (page Tr 126)

Special Committees to Council on Public Health

Cancer Control

Roy T. Forsberg, M.D., Chairman, Elizabeth

(Reference Committee "G")

The year 1974 encompassed numerous educational activities dovetailed with the Oncology Society of New Jersey and the New Jersey Division of the American Cancer Society.

Educational activities by many members of the Society span programs for physicians, nurses,

and para-medical personnel throughout the state.

It is hoped that the responsibilities of this committee will be enlarged, so as to make its representation a significant one.

Filed (page Tr 126)

Child Health

Glenn P. Lambert, M.D., Chairman, Flemington

(Reference Committee "G")

This committee reorganized on October 30, 1974, and met again on March 3, 1975. Action was taken on requests regarding the role of school physicians on child study teams, the

publication of guidelines of the new child abuse law, plus other cooperation with Division of Youth and Family Services concerning child abuse and neglect and pre-natal screening tests

(deemed practical and basic for the Department of Health to recommend). Topics concerning day care centers, infant stimulation programs, and early intervention plans, among others, were reviewed without specific recommendations.

The following recommendations were made to the Council on Public Health:

(1) That The Medical Society of New Jersey request that the New Jersey Department of Education require a child study team to submit to the consulting physician a summary of its findings, and classification; and, when holding conferences where special medical judgment is required, that the physician involved at least be asked to attend

and contribute if at all possible.

(2) That the council on Public Health cooperate with the Division of Youth and Family Services through this committee in dissemination of information on the new Dodd Child Abuse and Neglect Law (P.L. 1974, C.119), insofar as aiding in writing guidelines for professionals, preparing a special article for publication in *The Journal of MSNJ*, and cooperating with involved specialty societies protecting children from abuse; and that this committee and the Council on Public Health have input and feedback with the Division of Youth and Family Services on proposed amendments to the Dodd law.

Filed (page Tr 126)

Chronically Ill and Aging

David Eckstein, M.D., Chairman, Trenton

(Reference Committee "G")

Based on the following communication dated December 27, 1974,

"We are pleased to report that the AMA Council on Medical Service has authorized its Committee on Aging to cooperate with The Medical Society of New Jersey in organizing and conducting a one-day seminar on "The Role of the Medical Director in the Skilled Nursing Facility." This seminar will be held in conjunction with the AMA annual convention at the Holiday Inn, Atlantic City, June 16, 1975."

the Board of Trustees reactivated the Committee on the Chronically Ill and Aging.

David Eckstein, M.D., was appointed chairman and the following members of The Medical Society of New Jersey accepted membership on the Committee: Matthew E. Boylan, M.D., Werner J. Hollendonner, M.D., Michael K. Kurilla, M.D., A. Gerard Peters, M.D., and Nicholas E. Marchione, M.D. At its meeting on January 19, 1975, the Board of Trustees voted to accept the recommendation of the Committee on Aging and at the same time authorized an expenditure of not more than \$2,000 for this one-day seminar.

An initial meeting was held on February 11, 1975 with representatives from the various providers of long-term care and the one-day program scheduled for June 16, 1975 was structured and approved. All invited speakers have accepted and the Committee anticipates a substantial turnout in view of the demonstrated interest manifested by both physicians and providers of long-term care.

Upon the recommendation of the College of Nursing Home Administrators and the Non-Profit Home for Aging, the Committee agreed to explore the possibility of a continuing education program which would be directed toward Medical Directors, Administrators, and Nursing Supervisors.

The program will be recommended for six hours of credit in Class I of continuing education.

Filed (page Tr 126)

Conservation of Vision, Hearing, and Speech

Alfonse A. Cinotti, M.D., Chairman, Jersey City

(Reference Committee "G")

The results of the 1974 Eye Health Screening Program reveal that there were 92 Participating Centers and that 11,447 persons were screened.

6,473	Negative Results
4,974	Positive Results
546	Tonometry Suspects

In the discussion of the screening programs, it was noted that of the 10,883 screened in 1973, the Commission for the Blind reported that in their follow-up work, a total of 135 positive glaucomas were found from the program. This high percentage of glaucoma patients discovered from the annual screening program indicates the need for the continuance of the program as a prevention of blindness service to the citizens of New Jersey.

NEW JERSEY EDUCATION ASSOCIATION CONVENTION

The Lions Eye-Mobile was at the meeting in November in Atlantic City. Four hundred and ten persons were screened (all over thirty-five years of age). Audiologists screened for hearing

loss. Pamphlets on eye diseases were distributed as well as the "E" chart, which was very popular.

SUBCOMMITTEE ON HEARING

Rowan C. Pearce, Jr., M.D., Chairman, Haddonfield

MANDATORY SCREENING OF HEARING IN NEW JERSEY SCHOOLS

Permission was requested and granted to seek the assistance of Mr. Johnson and the Legal Counsel to amend legislation for the mandatory screening of hearing in New Jersey Schools. Dr. Pearce reports that Section 1 of P.L. 1969, chapter 217 (R.S. 18A: 40.4) has been amended in compliance with the rules set up by the New Jersey State Department of Education, and with the approval of the Board of Trustees of MSNJ, has been presented and accepted by Senator McGahn for introduction.

Filed (page Tr 126)

Environmental Health

Richard H. Musgnug, M.D., Chairman, Cherry Hill

(Reference Committee "G")

As a result of a resolution introduced by the Passaic County Medical Society at our Annual Convention in Atlantic City in May, 1974, The Medical Society of New Jersey adopted a resolution opposing the Tock's Island Dam until certain environmental questions, especially in reference to salmonella, could be resolved.

In response to this resolution, the Delaware River Basin Commission invited the Medical Society to meet with them. Dr. Gerald H. Rozan (delegate from Passaic County) and myself as

Chairman of the Special Committee on Environmental Health were selected to represent the Medical Society.

Our position was that the possibility of a salmonella epidemic resulting from the accumulation of these organisms in the sediment behind the dam was a serious problem and had not been studied. We made sure that the Corps of Army Engineers and the Delaware River Basin Commission were aware of this problem and the reasons why we felt it was a problem.

Since that time, an independent study commissioned by the Corps of Army Engineers has confirmed our position.

The purpose of our committee continues to be, in the main, educational and to that end, we have sent out a series of educational and instructive booklets on environmental health matters to the County Environmental Health Committee Chairmen.

We have also taken on the responsibility of developing an educationally informative exhibit at the annual convention of the Society in May,

1975. The theme for this exhibit will be "Smoking and Environmental Health."

The Committee has also given its full support to Bergen County's resolution calling for the Society to prohibit smoking at all official meetings of the Society and its Committees. We would like to urge the Council on Public Health to give the resolution its full endorsement. (The State Dental Society passed such a resolution several years ago.)

Filed (page Tr 127)



Officers and members of the Board of Trustees — 1975-1976

Maternal and Infant Welfare

Edward Foord, M.D., Chairman, Burlington

(Reference Committee "G")

The Committee met on two occasions, once in November and once in February, and reviewed the Standards of Obstetrical Care which has been forwarded to the Council on Public Health for its approval.

The Committee reviewed the available material on maternal deaths. Although, difficulties have been encountered in obtaining adequate data, it is hoped that future collection methods will alleviate this difficulty.

Twenty cases of maternal deaths were reviewed for 1973, a significant fact is that maternal death

totals are decreasing. Toxemia, ectopic pregnancies, and hemorrhage are still among the leading causes.

The Committee plans future meetings to review reported cases for 1974 and to submit selected case reviews for publication in *The Journal*.

The Committee wishes to request physician support in obtaining the full record of all cases of maternal deaths and wishes to give its assurance of complete confidentiality of records submitted.

Filed (page Tr 127)

Administrative Council

Public Relations

Howard D. Slobodien, M.D., Chairman, Perth Amboy

(Reference Committee "E")

The Council on Public Relations has continued its policy of gradual expansion of activities during the past year.

1. Continuing projects:

a. Publication and distribution of:

- (1) *Junior Health Hints* to schools and public libraries.
- (2) *Membership Newsletter*, including the annual compilation and distribution of a bound, indexed set to component societies.
- (3) *Periodic Newsletter* to cooperating agencies/individuals as required.

b. Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interests, and activities, including:

- (1) The Eye Health Screening Program.
- (2) The Annual Meeting, to include the Governor's Conference.
- (3) Child Safety Week.
- (4) Selected official programs and activities.

c. Responsibility for the information center and issuance of press releases at the Annual Meeting.

d. Responsibility for bestowal of the Golden Merit Award: 67 were bestowed in 1974, 27 in person, making a total of 809 since the Award's inception in 1957.

e. Encouragement of continuance — or establishment — of orientations programs for new members under the sponsorship of component societies.

f. Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the "Appendix Reference Information" of the *Membership Directory*.

g. Encouragement of Future Physicians Clubs in each county by acting as a clearing house at the State level.

h. Encouragement of increased voluntary blood donations.

i. Encouragement of radio broadcasts under the auspices of component medical societies. Plans have also been made to originate broadcasts at the Annual Meeting.

j. Encouragement of medical TV programs.

k. Diabetes Detection Week.

l. Placement service in *The Journal*. If possible, a booth will also be staffed at the Annual Meeting.

m. Physician Awards for Community Services:

- (1) A. H. Robins Award.
- (2) Sheen Award.

2. The requests of the membership for increasing lines of communication have been answered, in part by expanding the *Membership Newsletter* and by personal reports at the Conference for Presidents and Presidents-Elect.

3. Several referrals were considered:

a. From the Board of Trustees. It was agreed that members of the press, displaying official badges, be admitted to the sessions of MSNJ's House of Delegates. A resolution to this purpose will be introduced at the first session of the House.

b. From the Standing Committee on Annual Meeting. Consideration was given to the concept of a Silver Merit Award. This was reluctantly rejected when examination revealed such a large number of eligible recipients to render it impractical.

c. From the Standing Committee on Medical Student Loan Fund. The request for a "Distinguished Physicians' Fund" was discussed in detail and the following recommendations concurred in by the Board of Trustees:

- (1) That because the word "Distinguished" could not be properly defined, the Fund be made a memorial one and the name be changed to "Physicians' Memorial Fund".
- (2) That at least a \$5,000 minimum donation be set to establish this Fund and that it be open to other contributions.
- (3) That each county society be contacted to ascertain their loan fund activities and those of their women's auxiliaries.

4. We have agreed to subscribe to a full page ad in the *Journal 1975*, the yearbook published by the senior class of the College of Medicine and Dentistry of New Jersey.

5. We again supported Rider College's Pre-College Conference on Health Professions.

6. In order to further mutual activities, the Medical Societies of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York, and Pennsylvania sponsored a mutual hospitality suite at the Clinical Convention of the AMA in

Portland, Oregon. This type of liaison activity is to be pursued most vigorously.

7. A meeting was held with members of the medical industry. Our previous dialogue produced increased participation on their part at the 1974 Annual Meeting. It is expected that this positive trend will continue.

8. Senior medical students of New Jersey, Pennsylvania, and Wilmington will be invited to attend our Annual Meeting in Cherry Hill.

9. The Board of Trustees agreed, on our recommendation, to continue the informal dinner-meeting with State House correspondents.

10. Conferences with the Women's Auxiliary regarding the Medical Student Loan Fund were continued.

11. We met with the Society of Internal Medicine's legislative committee and legislators regarding bills of mutual concern.

12. A number of new activities were initiated:

a. The Massachusetts Medical Society invited us to share its successfully launched state-wide public service campaign on anti-self pollution. We agreed and have forwarded a usage fee of \$250 in order to study all the materials.

b. We accepted the offer of the New Jersey Public Broadcasting Company to act as sole sponsor for their series, *The*

Thin Edge; \$1500 was appropriated for the following five programs: Depression — March 31; Aggression — April 14; Guilt — April 28; Anxiety — May 12; Sexuality — May 26.

c. The Council on Public Relations will act as the publicity arm of the New Jersey Foundation for Health Care Evaluation on specified projects of mutual concern.

d. Meetings are in progress with the Office of Consumer Health Education of the College of Medicine and Dentistry of New Jersey. The Chairman of the Council, as Board representative to the OCHE, has noted that avoidance of duplication will produce a savings of time and money for both the MSNJ and the Medical School.

e. We have acted as consultants for display materials to be used in conjunction with the National High Blood Pressure Education Program.

f. We shall act as repository for materials furnished to local weekly newspapers by the CMDNJ.

g. MSNJ Christmas card was developed in keeping with the seasonal tradition of greeting between other state societies and professional organizations. The design is unique and conducive to continued recognition of the MSNJ.

The preparation of this report represented a most pleasant task. The members of the Council feel that real progress has been made in narrowing the communication gaps between the head and body of the MSNJ and between MSNJ and the public, our patients. We are pleased, but not satisfied; much remains to be done. The effective and willing participation of the Board of Trustees and of the Executive Staff of the MSNJ continue to smooth the way, and to them we offer our grateful thanks.

Filed with Commendation to the Chairman and his Committee members
(page Tr 122)



President-Elect and Mrs. McGuire



President Rogers and Mrs. McGuire

Special Committees

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

With the continued support by the Federal Government for Emergency Medical Services under Public Law 93-154, the Emergency Medical Services Systems Act of 1973 and other governmental assistance programs, emergency medicine is forging ahead continuously. Our committee remains active in various elements of emergency medical services.

HOSPITAL SIGNS

Since our Committee first proposed this project to the State Department of Transportation in 1971, with the approval of the Board of Trustees, i.e., the placing of hospital signs on major highways and thoroughfares in New Jersey, progress has been slow. However, as the significance of these signs took effect, momentum and interest have increased so that other than governmental agencies became involved in this important project. Hospital administrators are now requesting the placement of these signs. Their installation has been completed in seven counties — Bergen, Cape May, Mercer, Monmouth, Ocean, Passaic and Camden, through the offices of the Traffic Engineering Department, State Department of Transportation. This program is part of a national program widely accepted throughout the country.

TRAINING PROGRAM FOR EMERGENCY PHYSICIANS AND NURSES

With the approval of a grant by the Health Resources Administration, DHEW, a highly successful three-day program for physicians and nurses was held in the following hospitals in New Jersey: The Cooper Hospital, Camden; Burlington County Memorial Hospital, Mount Holly; Saint Elizabeth Hospital, Elizabeth; Jersey Shore Medical Center, Neptune; Monmouth Medical Center, Long Branch; St. Joseph's Hospital and Medical Center, Paterson; St. Francis Hospital, Trenton; Dover General Hospital, Dover; and Saint Peter's General Hospital, New Brunswick.

EMERGENCY TELEPHONES ON MAJOR HIGHWAYS

Contact was made with governmental agencies throughout the State as well as the State DOT to recommend the establishment of emergency telephones on major highways. The majority of responses showed great interest in this program while others indicated they were working toward its implementation. The Traffic Engineering Division of the State DOT has initiated a pilot project on Route 8 between Netcong and Denville. To gather more accurate information in the area of cost effectiveness of such a system, our committee is requesting information from those states where such systems already exist.

AIRPORT COMMUNITY EMERGENCY MEDICAL SERVICES

We have recommended that all airports have available plans for initiation in time of emergency. In this regard, a review of the current status of planning has been undertaken, designed to ensure an adequate response i.e., emergency medical response to the needs created by emergencies occurring at airports and their environs. Detailed information as to the location of all airports and heliports has been received from the State DOT, Division of Aviation.

EMERGENCY MEDICAL SERVICES TRAINING INSTITUTE

The Board of Trustees has approved the recommendation for the establishment of a Training Institute for Emergency Medical Services to serve all of New Jersey. The purpose of this Institute would be the development and coordination of emergency medical care training for physicians, nurses, and ambulance rescue personnel. This institute would be affiliated with the MSNJ in cooperation with The Academy of Medicine of New Jersey. The latter is the repository for continuing medical education for physicians. The development of this Institute would reduce the duplication of effort and cost of such programs. Feasibility and development

of this project will be determined at a meeting to be held and with the endorsement of the following organizations: The Medical Society of New Jersey, The Academy of Medicine of New Jersey, College of Medicine and Dentistry of New Jersey, Inter-Agency Commission on Emergency Medical Care, New Jersey Chapter, American College of Emergency Physicians, New Jersey Chapter, Emergency Department Nurses Association, and the New Jersey State First Aid Council.

INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE

Since the Inter-Agency Commission on Emergency Medical Care was organized on April 19, 1972, MSNJ, as the parent organization, has supported the work of the Commission very closely and practically on a daily basis. The Commission is composed of all major medical and allied medical organizations involved in emergency medical care. Since its inception, the Commission has received excellent financial support from the New Jersey Regional Medical Program. Monies set aside by the MSNJ for the Commission's continuance and operation have not been utilized because of the continued financial support by the NJRMP. However, in the event that NJRMP is phased out of existence or no funds can be made available to the Commission by the NJRMP, continued financial support will be required. Various projects undertaken by the Commission during the past three years that have been completed or are still underway include the following:

1. Emergency medical communications engineering surveys for the counties of Hunterdon, Mercer, Essex, Union, Hudson, and Bergen.
2. Programing and establishment of a data bank for hospital emergency department survey reports and categorization of hospital emergency department capabilities. A statewide conference was held on the subject of categorization of hospital emergency department capabilities in accordance with AMA standards.
3. Establishment of EMS Councils for the southern seven counties of New Jersey and also Bergen county, including an educational program for the public in EMS. The development of EMS councils throughout the state is an on-going program requiring educational stimulus.
4. With the cooperation of the New Jersey State First Aid Council and non-member squads, surveys of ambulance squads were completed.
5. A Training Program for Emergency Physicians and Nurses in cooperation with MSNJ was completed in 10 hospitals throughout the state.
6. Work toward the development of a Statewide Emergency Medical Care Plan was completed and encompasses the various components in accordance with the Emergency Medical Service Systems Act of 1973.
7. Members of the Commission have assisted and cooperated with various agencies involved in emergency medical services.

Recommendation

In the event that the NJRMP is unable to continue its financial support after June 30, 1975, it is recommended that the sum of \$10,000 be set aside for the continued work of the Commission.

Approved (page Tr 121)

Filed (page Tr 121)

Medicine and Religion

John J. Bedrick, M.D., Chairman, Bayonne

(Reference Committee "D")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed (page Tr 121)

Physicians' Relief Fund

Joseph J. Kline, M.D., Chairman, Trenton

(Reference Committee "B")

The Committee had applications for financial assistance submitted during the last year. Only one such application was completed and considered to be a valid request within the Committee's jurisdiction and responsibility. A meeting to assess the appropriateness and the extent of the need of a physician was held and a commitment made that permitted the Fund to meet an immediate emergency. Additional funds were granted for a total period of six (6) months.

The Committee hopes that continued publicity will be given in the publications of the various County Societies of the availability of financial assistance to members in need.

The Committee was gratified to receive an unsolicited contribution to the Fund from one of the members of the Mercer County Medical Society and hopes that members of other Societies will offer financial support to our fellow members who may experience severe

financial need.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee — approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1974-75 in support of the Physicians' Relief Fund.

Approved (page Tr 117)

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved (page Tr 117)

Filed (page Tr 117)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

New Federal Legislation in 1974 has brought about many new options in the pension law. Members of MSNJ should familiarize themselves with the plans approved by the Society and take advantage of these options. The annual reports from E. & W. Blanksteen Agency, plan administrators for the HR-10 (Keogh) Variable Annuity Retirement Investment Plan, and the Castle and Cannon Company, Inc., plan administrators for The PRO Flexible Retirement Plan, follow. Both of these retirement plan offerings are approved by The Medical Society of New Jersey.

HR-10 (KEOGH) VARIABLE ANNUITY RETIREMENT INVESTMENT PLAN

In 1974, the Keogh Law was liberalized so as to permit tax-deductible contributions up to the lesser of \$7500 or 15% of earned money. The Medical Society of New Jersey Retirement Plan Trust was modified accordingly and many members took advantage of this liberalization by increasing their contribution to the Plan and hence their tax deduction. In fact, the 1974 contribution by our members was 184% of the 1973 payment!

This Plan was established in 1970 following the success of the identical Essex County and Union County Medical Society Retirement Plan Trusts.

The program includes three unique advantages in addition to the well-known tax saving and tax shelter features of the Keogh Law:

1. A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity)
2. A death benefit guarantee, so that if the participant dies during the accumulation period, his beneficiary will never receive less than the amount the participant has paid in.
3. Flexibility during accumulation years, permitting the allocation and transfer of funds, at your option, to and from the common-stock account and the fixed-dollar account.

Internal Revenue Service approval for the Master Plan (with Serial Number 701115) was received November 30th, 1970.

Throughout the state we have 345 plans in effect covering 452 people with \$3,341,324 deposited by members of this program since inception.

CORPORATE MASTER RETIREMENT PLAN

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended and the Society approved in 1970, the establishment of The Medical Society of New Jersey Retirement Plan Trust-B, which adopted a Corporate Master Retirement Plan using the same funding agents as the Keogh program described above. This program, in the form of a Master Profit-Sharing Plan permits corporations, one of whose employees is a member of the Society, to place up to 15% of payroll in a tax-sheltered program with the same flexibility and options as our Keogh program using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity. Some of the useful and valuable features of this Master Plan are described below:

1. Eligibility Requirements — Employment 0 to 5 years — Minimum age up to 30
2. Flexible Retirement Date (especially valuable for older corporate officers)
3. Choice of contribution formulas including *Social Security integration*.

4. Vesting can be as minimal as nothing for the first five years under the plan and then 10% a year for the next ten years.

This plan is administered by E. & W. Blanksteen Agency, who will be pleased to furnish members with full information concerning this plan which should provide a substantial savings since it is not necessary to have a plan and trust especially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan including that of our administrator.

PRO FLEXIBLE RETIREMENT PLAN

The PRO Flexible Retirement Plan for our sponsored groups will embody two Trusts (A & B) providing a broad list of investment options and with all of the advantages of a trustee plan.

Trust A

Options

Regulated Investment Companies

Under this option, a participant may purchase one of six leading mutual funds, including PRO fund, our own common stock fund and PRO Income Fund, our income fund. Both of these Funds are no-load and a current prospectus on each is attached. The remaining four funds will have varied investment objectives and will include one short term money market fund.

Annuities

This option enables the participant to utilize the guaranteed and variable savings advantages of the life insurance company.

Life Insurance

Members may purchase ordinary life contracts and term insurance under favorable group underwriting terms not otherwise available on an individual basis.

U.S. Government Bonds — (Issued directly to participant)

This option allows a participant to buy a special series of self-employed Retirement Bonds. These Bonds are of particular value as a means of distribution after age 70½, since they are not taxed until the Bonds are redeemed.

Any Combination

Any of the above funding methods can be used in combination with any other or others so as to permit a tailor-made plan for all individual needs.

Trust B

Options

Regulated Investment Companies

Under this option, a participant may purchase one or more leading mutual funds, including PRO Fund, our own com-

mon stock fund, and PRO Income Fund, our income fund. Both of these Funds are no-load and a current prospectus on each is attached.

Savings Accounts

This option enables the participant to purchase passbook savings accounts or long term savings certificates.

Money Market Instruments

The participant may buy Treasury Bills, Certificates of Deposit and Commercial Paper.

Investment Advisor

This permits a member to have his account individually managed by a registered investment advisor.

Annuities

This option enables the participant to utilize the guaranteed and variable savings advantages of the life insurance company.

Life Insurance

Members may purchase ordinary life contracts and term insurance under favorable group underwriting terms not otherwise available on an individual basis.

U.S. Government Bonds

This option allows a participant to buy a special series of self-employed Retirement Bonds. These Bonds are of particular value as a means of distribution after age 70½, since they are not taxed until the Bonds are redeemed.

Common Stocks and Bonds

This option will allow any member to buy specific listed or over-the-counter securities of his choice.

Common Trust Fund

This option will allow a member to direct his investment to any Bank Common Trust Fund which has agreed to accept his account.

Automatic Stock Investment Plan

This will allow the participant to designate all or a portion of his account to be invested in an automatic stock investment plan administered by an institution designated in the adoption agreement.

Other Authorized Investments

Other investments authorized under the Code and the Act will be permitted.

Combinations

Any of the above methods can be used in combination with any other or others so as to permit a tailor-made plan for all individual needs.

Costs of Plans A & B

Plan A is limited to a total of six separate mutual funds, life insurance and annuity contracts and U.S. Retirement Bonds. All funds received from participants are invested once each month.

Plan B includes any investment authorized by the law and deemed appropriate by the Trustee.

<i>Fee Description</i>	<i>Plan</i>	
	<i>A</i>	<i>B</i>
Annual Service and Administration Fee — per participant	\$15.00	\$50.00
Annual Trustee Fee — Based on Total Assets	1/10th of 1%*	1/2 of 1%**
One time start-up fee — new plans	\$ 2.50	—
Transaction Fees — In excess of one annually	\$ 2.50	\$ 5.00
Transfer of investment options (each)	\$ 5.00	\$ 5.00
Insurance Policy Handling Fee (each)	—	\$ 5.00

*Minimum fee of \$7.50 per year.

**1/2 of 1% for first \$100,000., 1/4 of 1% next \$900,000., and 1/8 of 1% over \$1,000,000.

ADVANTAGES OF A TRUSTEED PLAN

A trusted plan can, depending on its provisions, offer a much broader and more flexible program for individual participants than possible under ordinary custodial arrangements. For example, most custodial plans are limited in their investment options, offering only the mutual funds and/or insurance policies.

By contrast, the retirement plan for The Medical Society of New Jersey will provide:

Numerous investment options.

The ability to combine options in any way permitted under the law.

Unlimited discretion to change during the funding years.

The right to transfer all assets completely out of the Plan to another Trusted Plan without liability of constructive receipt of premature distribution.

Options at take out on retirement time to help minimize tax liability.

Lastly, a word on corporate pension plans. The new pension code is very restrictive in the area of trustee functions; and it is our recommendation to physicians who have incorporated practices to be sure their retirement plans name a corporate fiduciary as the trustee. A trustee is exposed legally and must act in a prudent manner. The small savings a physician gains as his own trustee is far outweighed by the potential liability he may suffer by assuming a fiduciary responsibility.

The following fee structure will apply for those wishing to use a bank as the trustee for their pension plans. The plan's sponsor will provide a prototype plan, or if you already have a plan, the following fee structure will apply.

Plan A is limited to a total of six separate mutual funds, life insurance and annuity contracts and U.S. Retirement Bonds. All funds received from participants are invested once each month.

Plan B includes any investment authorized by the law and deemed appropriate by the trustee.

Fee Description	Plan	
	A	B
Annual Service and Administration Fee — per participant	\$50.00	\$50.00
Annual Trustee Fee — Based on Total Assets	1/10th of 1%*	1/2 of 1%**
One time start-up fee — new plans	\$ 2.50	—
Transaction Fees — In excess of one annually	\$ 2.50	\$ 5.00
Transfer of investment options (each)	\$ 5.00	\$ 5.00
Insurance Policy Handling Fee (each)	—	\$ 5.00

*Minimum fee of \$7.50 per year.
 **1/2 of 1% for first \$100,000., 1/4 of 1% next \$900,000., and 1/8 of 1% over \$1,000,000.

Filed (page Tr 119)



Henry J. Mineur, M.D., Speaker of the House of Delegates



James S. Todd, M.D., newly elected Chairman of the Board of Trustees



Hon. Brendan T. Byrne, Governor of New Jersey and President-Elect John J. McGuire, M.D.

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

During 1974 Blue Shield of New Jersey made every effort to focus on the greater needs of its subscribers and physicians.

Our board of trustees, its committees, our officers and staff endeavored to find and focus on these essentials.

Through careful listening and monitoring of mail and inquiries we determined these needs as: enrolling greater numbers of subscribers in better-payment programs; installing new systems which would bring improved service; establishing a Consumer Affairs Committee; enlisting more physicians in our full-payment program; and encouraging physicians to submit claims faster to enable us to make payments sooner.

BETTER PAYMENTS FOR MORE PEOPLE

To effect the first of these objectives we initiated promotional programs of every type throughout the year to inform the public of our two better-payment programs: the Series 750 and the Usual, Customary or Reasonable (UCR). These efforts included direct mail, radio, newspaper and magazine promotions. At year-end some 1,075,000 members were enrolled in the better-payment programs, which represents more than one quarter of our membership. And a goal was established to enroll more than half our members in these programs by year-end 1975. With the enrollment of some 600,000 state and municipal employees and their dependents in the Series 750, to become effective July 1, 1975, a giant step was taken toward achievement of this goal.

NEW SYSTEMS TO PROVIDE BETTER SERVICE

To bring about improved service we purchased and installed three new systems. These are the Cathode Ray Tube (CRT); the System for Telephone Administration Response (STAR); and, for Medicare Complementary subscribers, a coordinated tape-to-tape program with the Prudential Insurance Company, the Medicare Part B carrier.

The CRT, a teleprocessing system, is expected to bring vast improvements in claims processing when it is fully operational in mid-1975. It should enable us to cut five to seven days from claims processing time and will permit payment to subscribers and physicians in about half the time it now takes. The system enables immediate keyboard input of claims, and viewing on a video screen, eliminating much of the paperwork and several of the steps formerly required in feeding information into the computer system.

In addition, the new system will provide instantaneous information for subscribers or physicians on the status of claims, place, date and type of service, physician's name, IRS identifying number, address and whether or not the physician is participating. The new CRT system will also enable immediate recognition and correction of errors and will eliminate most lost claims. It also will report missing information or other problems.

STAR is an electronic telephone monitoring system designed to improve efficiency of service. Through prediction of peak inquiry hours it enables us to adequately staff our telephone service.

In another move to improve telephone service, we began planning for staffing branch offices in Morristown, Pennsauken, and Princeton with specialists in Blue Shield claims and benefits. Effective in early 1975, this meant that answers to many inquiries from subscribers or physicians could be quickly answered in their own areas without the necessity to call headquarters in Newark.

The next step will be to place CRTs in each of these offices which will make it possible to provide immediate answers to inquiries in most cases.

The Blue Shield-Prudential tape-to-tape system is designed to reduce and simplify the insurance phase of running a physician's office. When a

patient has Blue Shield Complementary coverage, it should eliminate two weeks processing time in those cases in which the doctor accepts Medicare assignment, or has been paid in full by the beneficiary. It eliminates the necessity for the doctor to file a separate claim form, provided the subscriber's identification number has been supplied to the Medicare carrier.

CONSUMER AFFAIRS COMMITTEE BRINGS BETTER FOCUS ON THE SUBSCRIBER

The Consumer Affairs Committee has looked into such items as telephone service and handling of complaints and has recommended certain actions to the board of trustees such as the eventual phasing out of the Series 500 program, which was deemed inadequate in today's market.

UCR PHYSICIAN PARTICIPATION WILL HELP SUBSCRIBERS — AND PHYSICIANS

The UCR program can only be as effective as its physician participation. This program, which provides paid-in-full benefits for eligible services regardless of subscriber income, is best for subscribers and physicians.

Our efforts in 1974 to enroll more participating physicians were made through personal calls, meetings and medical journal advertisements and resulted in a number of new participating physicians. Physicians who wish Blue Shield to replace its fixed-fee programs with a UCR program must help us to sell the program by increasing the numbers of UCR participating physicians. We are always happy to discuss the UCR program with physicians.

LITTLE PROGRESS IN CLAIMS SUBMISSION SPEED-UP

We made little headway in our objective of getting physicians to send in claims immediately after date of service. At year-end, on average, it was still almost 50 days from last date of service until the claims reached us. The problem is that patients assume claims have been submitted and look to us for action. We hope that 1975 will bring improvements in this lag time.

ENROLLMENT GROWTH

Almost 4,000,000 persons, or about 54 percent of the population of New Jersey, were enrolled in Blue Shield at year-end 1974. We passed the 4,000,000 mark early in 1975.

RESERVES DWINDLE

Our reserves for the protection of subscribers stood at about \$9 million at year-end 1974 and are decreasing at the rate of about \$1 million a month, necessitating filing in March, 1975 of an application for a premium rate increase. Principal reasons for the dwindling reserves were: a 10 percent decrease in premium rates ordered in 1973 by the former Commissioner of Insurance; a 10 percent increase in benefit payments affected by Blue Shield in 1973; increased benefits, utilization and operating expenses. These marked the first rate increases sought by the Plan since 1971 and those increases were effectively nullified by the 1973 rate decrease.

CLAIMS UP

Claims incurred for physicians' services were more than \$116 million in 1974, up from about \$111 million in 1973, an increase of \$5 million.

FOCUS ON THE FUTURE

A recent poll indicated that only three percent of the public considers health care to be among the major concerns facing the nation today. The public does not support radical restructuring of the health system or its financing. Nevertheless, we believe some form of National Health Insurance may become a reality in the not-too-distant future and we have started preparation for that event.

Blue Shield believes:

- There should be a working partnership of government with the private sector of the prepaid medical insurance industry in accordance with these basic principles:
- Free choice between provider and patient.
- Free choice of health care delivery system by the patient. The type of system should not be mandated by the Federal Government.

- Maximum use of the private health insurance industry to finance and administer the program. National Health Insurance should not be financed under the Social Security program.

- Federal financing limited to coverage of the poor and medically indigent.

Blue Shield stands ready to cooperate with the New Jersey Foundation for Health Care Evaluation and with PSROs. We hope to work with The Medical Society of New Jersey, and the Foundation in peer review activities.

We sincerely believe that Blue Shield and the physicians of New Jersey can continue to serve the health care needs of the state's residents through constructive change where it is needed, and with the benefit of our many years of experience at working together to help people to obtain and afford private medical care with free choice of physician and satisfactory doctor-patient relationship. This, we believe, is the best way to deliver medical care. Together we'd like to continue to focus on the subscriber.

OTHER HIGHLIGHTS OF 1974

- Major Medical continued to grow in popularity as a supplemental program to provide benefits for more serious illnesses and more extensive medical expenses. Almost 500,000 New Jersey Blue Shield group members are enrolled under this coverage. There are several coverage options available under this program, but the most prevalent one features a \$100 deductible with 80-20 percent coinsurance and a lifetime maximum of \$50,000.

- Mercer Medigroup, the state's first health maintenance organization, concluded 18 months of operation. An alternative to traditional Blue Cross-Blue Shield coverage, at year end 1974 it was serving more than 3,700 members. Planning for Blue Cross-Blue Shield participation in the state's second HMO in Vineland took place in 1974 and was to become effective in May, 1975.

- Blue Shield of New Jersey paid claims totaling more than \$2 million for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

- Blue Shield continued its health education program for organizations throughout the state. Booklets and films on the subjects of drug abuse, alcoholism and suicide were distributed.

- Total membership reached 3,990,325, an increase of 110,006, or 2.8 percent in 1974, covering more than 53.6 percent of the population of New Jersey.

- Total number of groups enrolled increased by 738 to 19,847.

- Usual, Customary or Reasonable Program membership grew by 135,813 to 775,009, a 21.2% increase.

- There were 283,298 persons enrolled in the Series 750 Fee Program.

- Nearly 11,000 persons enrolled during the Open Enrollment period.

- The Medicare Complementary Program grew by 13,589 to 200,520, of which 79.4% have the Extended Benefits Rider.

- There were 141,470 persons enrolled under the Federal Employee Program. Claims paid amounted to \$6,337,420.

PROVIDER UTILIZATION

Through its Physician Relations Section, Blue Shield endeavors to focus on the needs of its providers.

During 1974 efforts were greater than ever with the Field, Inquiry, Status and UCR Units making more visits, answering more questions and setting up more meetings and programs than ever before.

Continuing two-way communication is the goal of the Field Unit which is staffed by seven young people, including, for the first time, two women.

A total of 6,421 field contacts were made during 1974, an increase of 1,114 over 1973. Some 2,159 meetings were held in the offices of physicians and other providers. The Field Unit also conducted a series of hospital-based

seminars with 34 meetings being held from March 7 through May 15 resulting in a total attendance of 1,406 physicians and their office assistants. Subjects covered included National Reciprocity, No-Fault Auto Insurance and the Laboratory Disclosure law.

The Telephone Inquiry Unit answered some 52,777 questions, an increase of 9,883 over 1973. It answered 73,124 written inquiries, an increase of 4,630.

During 1974, the Status Unit made 6,241 changes in physician computer records.

The Usual, Customary or Reasonable Fee Unit handled 12,500 inquiries and requests for revisions during the year. Blue Shield is making every effort to increase physician participation in the UCR program and urges physicians throughout the state to seek information on it.

The Physician Relations staff would like to take this opportunity to thank the physicians of New Jersey for their services to Blue Shield subscribers. And it offers special appreciation to our participating physicians for their contributions to our service benefits program.

It has been possible to document savings in excess of \$5 million since the inception of the Utilization Review Program in 1967.

The objectives of the Utilization Review program are to recognize, prevent and eliminate the payment of ineligible benefits.

In 1974 there were savings of more than \$880,000 from all sources. This included more than \$768,000 as a result of pre-payment reviews in office laboratory and x-ray services which, it was determined, fell into the category of routine physical examinations which are not eligible. Other pre-payment reviews realized savings of over \$67,000. Included also in savings was more than \$43,000 in cash refunded to Blue Shield by 79 physicians.

These refunds resulted from findings of incorrect statements of anesthesia time, surgical and podiatry services and billings for services rendered by hospital-based salaried physicians and for services rendered by unlicensed

physicians.

POST PAYMENT AUDITS

Audits of physicians' claims completed after payments had been made were made at most New Jersey hospitals after a Plan representative had met with the hospital administrator and/or the Chief of Staff. Claims were selected at random and represented a cross section of all types of service, maternity, surgery, anesthesia and consultation.

ANESTHESIA SURVEY

The Utilization Review Section conducted a survey at 104 hospitals to determine trends in the use of Certified Registered Nurse Anesthetists. We found that: CRNA's were not employed in about 35 percent of the hospitals; were employed by 40 percent of the hospitals, 22 percent were physician-employed; and about 3 percent were employed by hospital physicians.

EDUCATIONAL POSTERS

Almost 10,500 educational posters bearing the message "use, don't abuse services" were sent to some 1,800 enrolled groups during the year. In addition a special Rider J poster was sent to 1,800 internists for display in their offices.

PHYSICIAN — LAB VISIT PROGRAM

A physician visitation program inaugurated in 1973 was continued in 1974. Visits were also made to bio-analytic laboratories. These visits were made when misunderstanding, overuse or possible abuse was apparent.

ANNUAL STATISTICS

Table 1

Distribution of All Underwritten Services and Payments made in 1974

Type of Service	Total Services	% All Services	Payment	% Total Payment	Payment Per Service
Surgical	832,841	31.3	\$ 53,349,008	48.8	\$ 64.06
Medical	1,501,485	56.3	34,517,582	31.5	22.99*
Obstetrical	46,181	1.7	9,544,263	8.7	206.67
Consultation	86,508	3.2	2,129,792	2.0	24.62
Anesthesia	199,058	7.5	9,882,783	9.0	49.65
Total	2,666,073	100.0%	\$109,423,428	100.0%	\$ 41.04

* Includes laboratory, x-ray, physical therapy, etc.

Table 2

Distribution of Community Rated Rider Services and Payments made in 1974

Type of Service	Total Services	% All Services	Total Payment	% Payment	Per Service
Surgical	79,321	15.6	\$1,573,457	21.1	\$ 19.84
Medical	3,227	0.6	217,333	2.9	67.35
Diag.	190,667	37.4	3,416,460	45.8	17.92
X-Ray					
X-Ray	870	0.2	154,765	2.1	177.89
Therapy					
Physical	9,134	1.8	165,542	2.2	18.12
Therapy					
Pathology	226,117	44.4	1,932,217	25.9	8.55
Total	509,336	100.0%	\$7,459,774	100.0%	\$ 14.65

Table 3

Distribution of Earned Subscription Income

Earned Subscription Income	\$126,221,017	100.0%
Incurred Claims	116,684,111	92.5
Surgical		45.1
Medical		29.1
Obstetrical		8.1
Anesthesia		8.3
Consultations		1.9
Operating Expense	16,533,324	13.1
Underwriting Gain (Loss)	(\$6,996,418)	(5.6)

Summary of Operations 1974

Incidence Rate—
Cases per 1000 Persons Enrolled 413

COMPARATIVE BALANCE SHEET DECEMBER 31, 1974

	1974	1973
<i>Assets</i>		
Investments	\$32,801,961	\$43,231,807
Accounts Receivable		
Subscriber Premiums	3,313,372	3,485,500
National Account Program	9,749,448	6,918,534
Federal Employee Program	2,937,815	1,991,944
Other	1,548,818	383,515
Accrued Income on Investments	509,788	709,646
Total Assests	\$50,861,202	\$56,720,946
<i>Liabilities</i>		
Provision for Medical and Surgical Claims	\$28,520,353	\$27,702,000
Excess of Outstanding Checks over Balance in Bank Accounts	1,769,181	1,883,994
Unearned Subscription Income	4,808,431	5,259,004
Accounts Payable	1,291,826	2,815,356
Reserve for Group Contract Settlement	3,476,352	2,682,026
Deposits from Organizations	1,910,603	1,566,349
Total Liabilities	\$41,776,746	\$41,908,729
<i>Reserves for Protection of Subscribers</i>		
General Reserve	\$ 100,000	\$ 100,000
Securities Evaluation	1,000,143	1,319,944
Unassigned	7,984,313	13,392,273
Total Reserves	\$ 9,084,456	\$14,812,217
Total Liabilities and Reserves	\$50,861,202	\$56,720,946

COMPARATIVE STATEMENT OF OPERATIONS

	1974	1973
Subscriptions Earned	\$126,221,017	\$116,539,539
Less:		
Claims Incurred	\$116,684,111	\$111,231,760
Operating Expenses	16,533,324	14,131,819
	133,217,435	125,363,579
Gain from Underwriting Operations	(6,996,418)	(8,824,040)
Income on Investments	2,281,583	2,606,830
Operating Loss for the Year	\$ (4,714,835)	\$ (6,217,210)

STATEMENT OF RESERVES FOR PROTECTION OF SUBSCRIBERS

	1974	1973
Reserves at Beginning of Year	\$ 14,812,217	\$ 19,887,224
Operating Loss for the Year	(4,714,835)	(6,217,210)
	10,097,382	13,670,014
Reserves Adjustment:		
Non-Admitted Assets	\$ (156,983)	\$ (1,356,038)
Unrealized Capital	(590,176)	(340,799)
Miscellaneous	(265,767)	126,964
	(1,012,926)	1,142,203
Reserves at End of Year	\$ 9,084,456	\$ 14,812,217

Filed (page Tr 118)

OFFICERS

John S. Robinson Executive Vice-President and Secretary-Treasurer	Joseph P. Donnelly, M.D., President	Francis J. Novak, Vice-President—Operations W. John Gould, Vice-President—Corporate Planning and Finance	Jerome C. Rothgesser, M.D. Vice-President—Medical Affairs
	Jean R. Geiger, Vice President—Communications		

BOARD OF TRUSTEES

Chairman of the Board Joseph M. Keating, M.D. (1976)		
First Vice President Rudolph C. Schretzmann, M.D. (1977)		Second Vice President John F. Waters (1976)
Donald T. Akey, M.D. (1975)	Mortimer J. Fox, Jr. (1976)	William Mortenson (1975)
Edwin H. Albano, M.D. (1977)	Frederick L. Hipp, Ed. D. (1975)	John R. Nevin (1976)
Robert G. Boyd (1975)	Josephine B. Janifer (1975)	Zelda J. Paulsen (1977)
Thomas C. Butler (1977)	John Kelley (1977)	James A. Rogers, M.D. (1975)
A. Guy Campo, M.D. (1976)	Samuel J. Lloyd, M.D. (1977)	Ronald K. Seywert (1976)
William M. Chase, M.D. (1977)	Theron L. Marsh (1977)	*Warren H. Simmons, Jr. (1975)
Joseph A. Cox, M.D. (1975)	John J. McGuire, M.D. (1976)	Sidney I. Simon, Ph.D. (1975)
*Charles L. Cunniff, M.D. (1975)	Walter H. Miller, D.O. (1976)	Morgan Sweeney (1975)
Edgar P. Eaton, Jr. (1976)	Henry J. Mineur, M.D. (1976)	Charles O. Tyler, M.D. (1977)
Lloyd M. Flemly (1977)		Robert E. Verdon, M.D. (1975)

TRUSTEES EMERITUS

	Appointed	Term as Board Member
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.	1971	1962-1971
John S. Thompson	1966	1942-1965
Thomas J. White, M.D.	1973	1951-1973

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	Term as Board Member
William F. Costello, M.D.	1958	1948-1958
Andrew P. Dedick, M.D.	1973	1961-1973

CONSULTANT TO CHAIRMAN OF BOARD

	Appointed	Term as Board Member
Irving P. Borsher, M.D.	1965	1950-1965
*Resigned		

New Jersey Participating and Non-Participating Physicians — UCR Program

By County	Total Elig. Phys.	Total	M.D.	Participating D.O.	Lab.	Total	M.D.	Non-Participating D.O.	Lab.	% P.P. 12-31-74	% P.P. 12-31-73
Atlantic	319	313	274	18	4	6	6	14	2	98.1	98.0
Bergen	1493	812	695	66	15	681	656	19	9	54.3	54.8
Burlington	361	341	271	53	2	20	19	1		94.4	94.8
Camden	910	823	560	215	7	87	79	4	3	90.4	89.1
Cape May	83	82	61	16	2	1	1	1		98.7	98.7
Cumberland	163	157	135	9	3	6	5	1		96.3	94.1
Essex	1880	1504	1390	42	9	376	367	4	1	80.0	79.9
Gloucester	194	174	119	40	3	20	19	1	4	89.6	88.8
Hudson	830	695	634	19	9	135	130	2	2	83.7	84.6
Hunterdon	79	72	72	18	4	7	7	3	1	91.1	92.1
Mercer	648	508	466	18	20	140	137	3		78.4	79.0
Middlesex	706	518	470	21	17	188	178	3	5	73.4	73.0
Monmouth	693	523	485	21	14	170	164	5	2	75.5	74.6
Morris	592	477	436	26	10	115	110	4	1	80.6	82.8
Ocean	302	193	163	21	8	109	99	8	1	63.9	63.1
Passaic	769	600	530	35	26	169	166	2	1	78.0	75.7
Salem	63	61	48	10	2	2	2	1		96.8	95.0
Somerset	262	224	213	5	4	38	36	1	1	85.5	85.7
Sussex	96	93	85	6	1	3	3			96.9	95.4
Union	946	714	606	60	40	232	226	2	3	75.5	75.3
Warren	75	69	64	2	1	6	6			92.0	89.7
Out of State	291	283	232	44	6	8	8			97.1	95.3
Total	11755	9236	8013	747	375	2519	2424	53	24	78.6	78.4
<hr/>											
By Specialty											
Anes.	568	345	322	23		223	220	3		60.7	56.6
Derm. Syph.	202	130	129	1		72	72			64.3	65.3
Int. Med.	1930	1439	1392	47		491	491			74.5	74.7
Neur. Surg.	120	80	79	1		40	40			66.7	65.0
Obst.-Gyn.	929	750	728	22		179	177	2		80.7	78.3
Ophth.	432	263	258	5		169	169			60.9	62.4
Orth. Surg.	437	307	297	10		130	130			70.3	67.1
Otol.	251	164	157	7		87	86	1		65.3	65.8
Path.	215	175	170	5		40	39	1		81.7	81.7
Ped.	739	657	649	8		82	82			88.9	87.8
Phys. Med.	39	29	27	2		10	10			74.3	80.0
Plast. Surg.	77	32	31	1		45	45			41.6	39.3
Anal. Labs.	119	101			101	18			18	84.8	90.2
Proct.	41	20	14	6		21	21			48.7	48.7
Psy. & Neuro.	665	473	463	10		192	192			71.1	71.4
Radiology	400	314	297	17		86	86			78.5	81.6
Surg.	1104	866	834	32		238	237	1		78.4	77.6
Thor. Surg.	79	66	66			13	13			83.5	80.8
Urol.	288	180	175	5		108	108			62.5	58.1
Podiatry	399	375				24			24	93.9	94.5
General	2721	2470	1925	545		251	206	45		90.7	91.0
Total	11755	9236	8013	747	375	2519	2424	53	24	78.6	78.4

New Jersey Participating and Non-Participating Physicians — Basic Program

By County	Total Elig. Phys.	Total	M.D.	Participating D.O.	D.P.M.	Lab.	Total	M.D.	Non-Participating D.O.	D.P.M.	Lab.	% P.P. 12-31-74	% P.P. 12-31-73
Atlantic	319	273	239	16	15	3	46	41	2	2	1	85.6	85.3
Bergen	1493	683	591	54	27	11	810	760	26	18	6	45.7	46.1
Burlington	361	277	214	50	11	2	84	76	4	4		76.7	75.4
Camden	910	741	508	190	37	6	169	131	29	7	2	81.4	80.1
Cape May	83	64	49	11	3	1	19	13	5		1	77.1	74.6
Cumberland	163	138	122	8	5	3	25	22	2	1		84.7	81.1
Essex	1880	1255	1165	32	48	10	625	592	14	16	3	66.7	67.1
Gloucester	194	151	99	38	12	2	43	39	3		1	77.8	75.9
Hudson	830	579	529	16	28	6	251	235	5	7	4	69.7	69.8
Hunterdon	79	64	64				15	15				81.0	76.3
Mercer	648	453	414	16	19	4	195	189	5	1		69.9	69.7
Middlesex	706	427	386	17	17	7	279	262	7	2	8	60.5	60.6
Monmouth	693	395	367	16	11	1	298	282	10	4	2	56.9	60.6
Morris	592	393	357	21	10	5	199	189	9	1		66.4	67.5
Ocean	302	163	138	17	7	1	139	124	12	2	1	53.9	55.8
Passaic	769	499	445	30	19	5	270	251	5	9	5	64.9	64.9
Salem	63	55	45	7	2	1	8	5	3			87.3	85.0
Somerset	262	187	176	5	4	2	75	73	1	1	1	71.4	71.1
Sussex	96	74	69	4	1		22	19	2		1	77.1	77.2
Union	946	574	485	53	31	5	372	347	9	10	6	60.7	59.4
Warren	75	63	60	1		2	12	10	1	1		84.0	80.8
Out of State	291	163	129	29	5		128	111	15	1	1	56.0	51.9
Total	11755	7671	6651	631	312	77	4084	3786	169	87	42	65.2	65.2

By Specialty

Anes.	568	356	335	21			212	207	5			62.7	62.1
Derm. Syph.	202	106	105	1			96	96				52.5	54.9
Int. Med.	1930	1249	1209	40			681	674	7			64.7	64.4
Neur. Surg.	120	60	59	1			60	60				50.0	49.5
Obst.-Gyn.	929	653	632	21			276	273	3			70.3	70.1
Ophth.	432	243	241	2			189	186	3			56.2	55.5
Orth. Surg.	437	216	207	9			221	220	1			49.4	50.1
Otol.	251	137	130	7			114	113	1			54.6	53.4
Path.	215	124	122	2			91	87	4			57.7	58.4
Ped.	739	516	509	7			223	222	1			69.8	67.3
Phys. Med.	39	20	19	1			19	18	1			51.3	60.0
Plast. Surg.	77	24	23	1			53	53				31.2	25.7
Analy. Labs.	119	77				77	42				42	64.7	69.0
Proct.	41	24	19	5			17	16	1			58.5	60.9
Psy. & Neuro.	665	391	381	10			274	274				58.8	60.1
Radiology	400	252	237	15			148	146	2			63.0	63.8
Surg.	1104	734	703	31			370	368	2			66.5	66.7
Thor. Surg.	79	51	51				28	28				64.5	55.8
Urol.	288	166	161	5			122	122				57.6	54.8
Podiatry	399	312			312		87			87		78.2	76.9
General	2721	1960	1508	452			761	623	138			72.0	72.1
Total	11755	7671	6651	631	312	77	4084	3786	169	87	42	65.2	65.2

New Jersey Foundation for Health Care Evaluation

Charles S. Krueger, M.D., Treasurer, Mt. Holly

(MSNJ Reference Committee "B")

This 1975 interim financial report of your Treasurer has been prepared from the books and records, covering only the Foundation Account, of the New Jersey Foundation for Health Care Evaluation.

The Balance Sheet is presented as of March 31, 1975 and May 31, 1974. Figures at March 31, 1975 have not been audited, for the reason that the fiscal year of the Foundation does not end until May 31, 1975. The figures at May 31, 1974 have been abstracted from the report of audit dated July 29, 1974.

The Statement of Revenue Expenditures and Fund balances present the transactions of the organization's Foundation Account for the ten months ended March 31, 1975.

Revenues have been examined on a test basis and disbursements have been test checked to approved supporting vouchers by the Foundation's independent accountants. The cash balance at March 31, 1975 was reconciled with the bank statement but was not confirmed with the depository. Revenues from grants were checked to the supporting detail on file, but were not independently confirmed at this time. The savings account and investment were not physically examined or confirmed at March 31, 1975.

These financial statements have been prepared in conformity with Resolution #28 approved by the 1968 House of Delegates of The Medical Society of New Jersey under the heading "Annual Financial Report."

Filed with notation (page Tr 117)

BALANCE SHEET — FOUNDATION

Assets	March 31, 1975 (Unaudited)	May 31, 1974 (Audited)
General Fund		
Cash (Page Tr 89)	\$19,843.54	\$15,442.45
Investments — at cost (Page Tr 89)	39,468.20	-----
Accounts Receivable	10,669.03	4,974.02
Accrued Interest Receivable	354.55	-----
Furniture and Equipment — at cost	2,154.65	-----
	<u>\$72,489.97</u>	<u>\$20,416.47</u>
Special Escrow Fund		
Cash	920.00	910.00
Totals	<u>\$73,409.97</u>	<u>\$21,326.47</u>

LIABILITIES AND FUND BALANCES

General Fund

Unexpended Budget Appropriations

(Page Tr 88)	\$62,754.32	\$	-----
Accounts Payable	25.00		2,208.13
Payroll Taxes Accrued and Withheld	518.89		796.78
Deferred Income — New Jersey Association of Osteopathic Physicians and Surgeons	-----		600.00
	63,298.21		3,604.91

Funds for Specific Purposes:

New Jersey Regional Medical Program, Inc.	-----		2,262.41
Furniture and Equipment	2,154.65		-----
	2,154.65		2,262.41

General Fund Balance (Unappropriated)	7,037.11		14,549.15
	72,489.97		20,416.47

Special Escrow Fund

Foundation Application Fees	920.00		910.00
Totals	\$73,409.97		\$21,326.47

STATEMENT OF REVENUE, EXPENDITURES AND FUND BALANCES FOR THE TEN MONTHS ENDED MARCH 31, 1975 (UNAUDITED)

	General Unappro- priated	Fund Specific Purpose	Special Escrow Fund
Revenue			
Medical Society of New Jersey Grant	\$69,280.00		
New Jersey Association of Osteopathic Physicians and Surgeons Grant	6,000.00		
Interest Income from Investments and Savings Accounts	401.96		
Application Fees			\$ 10.00
	75,681.96		10.00
Expenditures			
Budget Appropriations (12 months)	83,194.00		
New Jersey Regional Medical Program, Inc.		\$1,541.61	
	83,194.00	1,541.61	
Excess of Expenditures over Revenue — Before Adjustments	(7,512.04)	(1,541.61)	10.00
Adjustments			
Cancellation of Unexpended Balance From New Jersey Regional Medical Program, Inc. Grant		720.80	
New Increase (Decrease) in Fund Balances			
From Operations	(7,512.04)	(2,262.41)	10.00
Fund Balance			
Balance, Beginning	14,549.15	2,262.41	910.00
Balance, Ending	\$ 7,037.11	\$ -----	\$920.00

STATEMENT OF EXPENDITURES
FOR THE TEN MONTHS ENDED MARCH 31, 1975
(UNAUDITED)

	Adopted Budget	Total Expended	Balance Unexpended
Administrative Director's			
Salary	\$21,000.00	\$ 2,749.80	\$18,250.20
Medical Director's Salary	-----	5,133.30	(5,133.30)
Executive Secretary's Salary	10,000.00	2,125.63	7,874.37
Clerk-Secretary's Salary	6,500.00	280.00	6,220.00
Payroll Taxes	2,353.00	836.71	1,516.29
Employee Benefits, Health			
Insurance, Life Insurance			
and Pension	1,000.00	127.24	872.76
Rent	6,929.00	-----	6,929.00
Furniture Rental	2,862.00	-----	2,862.00
Furniture Purchases	-----	2,154.65	(2,154.65)
Insurance	300.00	-----	300.00
Special Projects	1,500.00	-----	1,500.00
Supplies and Stationery	4,000.00	1,309.07	2,690.93
Postage	3,025.00	167.19	2,857.81
Telephone	1,725.00	343.11	1,381.89
Legal Fees	3,000.00	691.37	2,308.63
Accounting Fees	1,000.00	358.00	642.00
Consultants' Fees	10,000.00	-----	10,000.00
Maintenance Worker	1,500.00	139.50	1,360.50
Conferences and Travel:			
President, Administrative			
Director, and Others	2,500.00	3,242.54	(742.54)
Mileage and Parking	1,000.00	245.53	754.47
Meetings and Conferences,			
Provider Relations	3,000.00	536.04	2,463.96
Total Budget Appropriations	<u>\$83,194.00</u>	<u>\$20,439.68</u>	<u>\$62,754.32</u>

STATEMENT OF REVENUE, EXPENDITURES AND FUND BALANCE
NEW JERSEY REGIONAL MEDICAL PROGRAM, INC. GRANT
FOR THE TEN MONTHS ENDED MARCH 31, 1975
(UNAUDITED)

Expenditures	
Salaries	
Administrative	\$ 750.20
Secretary	612.00
Fringe Benefits	147.51
Conferences	31.90
	<u>1,541.61</u>
Excess of Expenditures over Revenue	
Before Adjustments	(1,541.61)
Adjustments	
Cancellation of Unexpended Balance	
From New Jersey Regional Medical	
Program, Inc. Grant	<u>720.80</u>
Net Decrease in Fund Balance From Operations	(2,262.41)
Fund Balance	
Balance, Beginning	<u>2,262.41</u>
Balance, Ending	<u>\$ —0—</u>

ANALYSIS OF CASH
MARCH 31, 1975
(UNAUDITED)

	Balance March 31, 1975	Interest Income
General Fund		
New Jersey National Bank		
Treasurer's General Account	\$ 4,296.13	\$ ———
General Fund Savings Account	15,047.41	47.41
Cash on Hand — Office Petty Cash Fund	500.00	———
	<u>\$19,843.54</u>	<u>\$ 47.41</u>
Special Escrow Fund		
New Jersey National Bank Treasurer's General Account	<u>920.00</u>	

ANALYSIS OF GENERAL FUND INVESTMENTS AND INCOME THEREON
MARCH 31, 1975
(UNAUDITED)

	Due Date	Cost	Maturity Value	Yield	Interest Income
N.J. National Bank U.S. Treasury Bill	5/1/75	\$39,468.20	\$40,000.00	5.606%	\$354.55

Supplemental Report

The Foundation has been very busy since the last meeting of this Society, and activities are increasing. Staff consists of Mr. Thomas J. Crane, Administrative Director, Mrs. Patricia A. Houston, R.N., Assistant Director, Daniel J. O'Regan, M.D., and an office staff. We continue to rent space in the MSNJ building, and will soon be occupying part of the "Carriage House," also on a rental basis. We receive splendid support and cooperation from all MSNJ personnel in the building.

The past year has seen the filing of proposals for funding with HEW. Three PSRO areas have received funds as Planning PSROs. The five remaining in New Jersey have not received any Government money; four of these filed plans and requests, and the fifth recently was organized. These all required considerable help from the Foundation. In the past few weeks, DHEW announced new criteria for Planning proposals and the "five" have had to submit new proposals. Our own Support Center contract requires that we prepare a request for funds as well. All these proposals and plans require a great deal of technical and mechanical activity, as well as considerable time, and our people have been involved every step of the way.

We also have been the focal point for bringing together many agencies and organizations involved in all aspects of "health care" — HEW (national and local), of New Jersey Department of Health, the New Jersey Hospital Association, fiscal intermediaries and other "carriers," hospitals, medical societies, nurse coordinators and other non-physician professionals, and so on. We keep in mind that our origins are here, among the practicing physicians of New Jersey, in all these meetings and negotiations. The continuing discussions have helped all of us. Not all problems are on the doctor's side.

Other than organizational PSRO Support, some of our activities include:

Our Committee on In-House Review spent several months reviewing methods of gathering and processing information.

Our consortium, including intermediaries, PSROs, Medicare and Medicaid agencies, meets monthly, and is nearing the point when information systems will be selected. We feel that a single, statewide system should work in New Jersey, and that the doctors would control the quality elements of it.

We participate in the State Department of Health deliberations on the HMO process in New Jersey.

We participate in the New Jersey Utilization Project of the New Jersey Hospital Association.

We have established a committee for the investigation of claims review projects.

We have participated in offering advice and assistance to the Governor in the selection of Health Services Areas under the Health Planning and Resources Development Act.

Mrs. Houston has prepared a training program for nurse coordinators in preparation to meet the "new" regulations for Medicare and Medicaid. She has conducted programs on the subject recently in Ohio, Georgia and Illinois.

Monthly articles are appearing in *The Journal* and *Newsletter* of MSNJ (thanks to the editors), and our own newsletter is in circulation.

We have prepared slide programs, which have been in considerable demand around the State.

We maintain close contact with other organizations; besides AMA and other professional groups, these include the American Association of Foundations for Medical Care, of which we are a voting member, and the National Professional Standards Review Council.

Our Board of Trustees and Executive Committee have been extremely faithful in guiding the activities of the Foundation. Meetings are held monthly; this means double duty for the Executive Committee members. The Board has broad representation: all component societies of MSNJ, the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey Hospital Association, Medical-Surgical Plan, Blue Cross, Prudential, Health Insurance Council; and William J. D'Elia, M.D., has had an active and fruitful year as President.

We deeply appreciate the support of MSNJ. These early years have not been easy. We all ventured forth on new processes. The effects of recession and inflation have delayed the timetable somewhat. The introductions of the "new" regulations last November, and the appearance of the Health Planning and Resources Act in January, gave us new targets for our attention. We have guarded our resources carefully, so that we did not request any additional funds from this body at this meeting. We would like to leave the door slightly ajar, however, should such a request become necessary in the future. We do use some of the funds which you provided in the past, for instance, in hiring consultants for non-PSRO activities.

We feel that our presence is definitely being felt not only in New Jersey, but in other areas as well. The practicing physicians of this State have a voice wherever we go. Others are listening to us; we hope that you will continue to inform yourselves of the gathering forces attempting to interfere between you and your patients. Physicians need to be in the thick of things; we are in the arena, representing *you* and no one else.

Filed with notation (page Tr 117)



House of Delegates — First Session, May 31, 1975

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1975 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County

Vincent J. DiNicolantonio, M.D., Brigantine; Age 66
Max Gross, M.D., Ventnor City; Age 72
Morton D. Ritter, M.D., Ventnor City; Age 61
Sidney Rosenblatt, M.D., Atlantic City; Age 81

Bergen County

Anthony S. Raimo, M.D., Franklin Lakes; Age 51

Burlington County

Charles F. Kutteroff, M.D., Vincentown; Age 82

Camden County

Herbert F. Johnson, M.D., Woodbury; Age 66

Cumberland County

G. Anthony Mascara, M.D., Vineland; Age 63

Essex County

William G. Bernhard, M.D., Short Hills; Age 71
John K. deVries, M.D., Summit; Age 75
Eugene Greenwald, M.D., Rockaway; Age 74
James B. Gulick, M.D., So. Orange; Age 71
Edward G. Gullord, M.D., Bridgehampton, N.Y. (formerly Glen Ridge); Age 68
Stuart Z. Hawkes, M.D., Rio Rancho, N.M. (formerly Newark); Age 70
Carye-Belle Henle, M.D., Kinnelon; Age 77
Theodore Hirsch, M.D., Orange; Age 75
Albert E. Holderith, M.D., W. Caldwell; Age 62
Harry M. Holtz, M.D., W. Orange; Age 66
Charles O. Leff, M.D., S. Orange; Age 76
Fulton Massengill, M.D., Short Hills; Age 71
George H. C. McKeown, M.D., Norristown, Pa. (formerly Verona); Age 67
Alexander E. Nash, M.D., Verona; Age 80
Julian M. Ney, M.D., Maplewood; Age 75
Sigismund J. Ostrowski, M.D., Manasquan; Age 70
Paul J. Russomanno, M.D., Newark; Age 64
George F. Simms, M.D., Saylorsburg, Pa. (formerly Lyndhurst); Age 73
Richard H. Smith, M.D., Green Valley, Ariz. (formerly Nutley); Age 66
Samuel A. Weiss, M.D., Vero Beach, Fla. (formerly E. Orange); Age 66
Robert R. White, Jr., M.D., Vineyard Haven, Mass. (formerly E. Orange); Age 79

Gloucester County

Isaac N. Patterson, M.D., Westville; Age 67

Hudson County

Henry A. Christian, M.D., Asbury; Age 73
William V. Harz, M.D., Spring Lake; Age 65
John P. Coughlin, M.D., Brick Town; Age 69

Middlesex County

Alphonse F. Normand, M.D., Perth Amboy; Age 73
Irving Zuckerberg, M.D., Willingboro; Age 63

Passaic County

Edward C. Edlkraut, M.D., Passaic; Age 68
Abraham M. Fiering, M.D., Wayne; Age 77
Elias J. Hatem, M.D., Paterson; Age 70
David B. Levine, M.D., Hollywood, Fla. (formerly Fair Lawn); Age 74
Herman Levy, M.D., Passaic; Age 83

Salem County

Richard R. Lamb, M.D., Woodstown; Age 63
Harry F. Suter, M.D., Penns Grove; Age 73
John Zappala, M.D., Penns Grove; Age 70

Somerset County

Godfrey S. Hyer, M.D., St. Petersburg, Fla. (formerly Somerville); Age 66
Arthur F. Mangelsdorff, M.D., Jamesburg; Age 71
C. Scott McKinley, M.D., Bound Brook; Age 62

Union County

Francis J. Grant, M.D., Johns Island, S.C. (formerly Hillside); Age 66
Estelle T. Milliser, M.D., Summit; Age 67
Saul A. Naidorff, M.D., Plainfield; Age 75
Philip Owen, M.D., Jamesburg; Age 69
S. Lawrence Samuels, M.D., Lauderhill, Fla. (formerly Plainfield); Age 69
Frederick F. Senerchia, Jr., M.D., Elizabeth; Age 69
William O. Wuester, M.D., Elizabeth; Age 68

Warren County

John J. McDonald, M.D., Belvidere; Age 55

Approved (page Tr 128)

Supplemental Report

The following additional nominations for election to emeritus membership have been received:

Essex County

Arthur J. D'Alessandro, M.D., Newark; Age 64
William M. Kennedy, M.D., Charlotte, North Carolina (formerly Verona); Age 73
William B. Nevius, M.D., Short Hills; Age 70
Marie A. Sena, M.D., Toms River; Age 70

Approved (page Tr 128)

MEMORIAL RESOLUTIONS

The following resolution was received by the House with sorrowful concurrence.

Louis Keeler Collins, M.D. (1911-1974)

Whereas, after a rich life of distinguished and exemplary service as a renowned physician and outstanding medical leader, Louis Keeler Collins, M.D., our beloved colleague has been called to his eternal reward; and

Whereas, in his years as a member, Doctor Collins consistently rendered splendid service to The Medical Society of New Jersey, as President, Trustee, and Chairman of the Council on Medical Services, to name but a few of the offices he graced; and

Whereas, in his medical practice he always exemplified the attributes of a true humanitarian and distinguished physician; and

Whereas, by his gentle graciousness, ever-present humor and charming wit he won the affections of all with whom he came in contact; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring Louis Keeler Collins, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow and family in token of heartfelt sympathy.

RESOLUTIONS

#1

AMA Issues Workshop

From the Passaic County Medical Society

(Reference Committee "A")

Whereas, it is essential that The Medical Society of New Jersey's Delegates to the AMA be fully informed and aware of the relevant opinions and wishes of MSNJ members, if the Delegates are effectively to represent them at AMA meetings; and

RESOLVED, that a special workshop meeting for the above-stated purposes be set up each year as an integral part of the meeting program of MSNJ's annual meeting.

Whereas, it is important that members of MSNJ feel that they have the opportunity and an effective mechanism to transmit their opinions and wishes to MSNJ Delegates to the AMA; now therefore be it

Faregoing "resolved" amended to read:

RESOLVED, that a special workshop meeting for the above-stated purposes be set up for a one-year trial period as an integral part of the meeting program of MSNJ's annual meeting.

Adopted as amended by the Reference Committee (page Tr 115)

#2

Conflict of Interest on the Part of Members of the Board of Trustees and Officers of The Medical Society of New Jersey

From the Union County Medical Society

(Reference Committee "A")

Whereas, the Board of Trustees of The Medical Society of New Jersey bears an essential and significant responsibility for the conduct of the affairs of the Society; and

Whereas, employment on a full-time basis by a third-party payor does represent such a definitive conflict of interest; now therefore be it

Whereas, the Officers and Board of Trustees of The Medical Society of New Jersey exert considerable influence over the professional lives of physician members and must be prepared to act on vital issues that affect the relationship of The Medical Society of New Jersey to third-party carriers; and

RESOLVED, that the House of Delegates recommend that no physician employed on a full-time basis by a third-party payor be permitted to serve as an officer or as a member of the Board of Trustees of The Medical Society of New Jersey; and be it further

Whereas, those physicians serving as officers and members of the Board of Trustees should have no other interest which could conceivably represent a source of conflict with their stated duties as Trustees; and

RESOLVED, that this matter be referred to the Standing Committee on Revision of Constitution and Bylaws for implementation.

Rejected (page Tr 116)

#3

Repeal Earnings Test for Social Security

From Robert E. Jennings, M.D., Delegate, Essex County

(Reference Committee "A")

Whereas, wage earners making over \$2,500 are not entitled to Social Security benefits; and

Whereas, retired people on pensions and earnings from securities may earn unlimited amounts from these sources and still receive monthly Social Security benefits; and

Whereas, Senate Bill No. 410 introduced in the United States Senate would abolish the Social Security retirement test and allow retired citizens receiving Social Security benefits to earn unlimited income after age 65 without being penalized; now therefore be it

RESOLVED, that The Medical Society of New Jersey use its resources and facilities to actively support the passage of United States Senate Bill No. 410; and be it further

RESOLVED, that The Medical Society of New Jersey urge the American Medical Association through introduction of a resolution at their June 1975 Convention, actively to support the passage of United States Senate Bill No. 410.

Adopted (page Tr 116)

#4

Funding for the New Jersey Foundation for Health Care Evaluation

From the Union County Medical Society

(Reference Committee "B")

Whereas, the New Jersey Foundation for Health Care Evaluation has received substantial funds from the federal government; now therefore be it

RESOLVED, that no additional money from The Medical Society of New Jersey be given to the New Jersey Foundation for Health Care Evaluation.

Amended by Reference Committee as follows:

Whereas, the New Jersey Foundation for Health Care Evaluation has received substantial funds from the Federal Government for the operation of the PSRO Support Center; and

Whereas, the Foundation has adequate funds for the conduct of its MSNJ activities; and

Whereas, the Foundation has requested no additional funds from MSNJ for the fiscal year 1975-76; now therefore be it

RESOLVED, that no additional money from MSNJ be given to the New Jersey Foundation for Health Care Evaluation at this time.

Adopted as amended by the Reference Committee (page Tr 117)

#5

Malpractice Insurance

From the Cumberland County Medical Society

(Reference Committee "C")

Whereas, the cost of malpractice insurance has risen to such a level that it imposes a hardship on providers of health care services; and

State of New Jersey cooperates with other states and federal authorities to establish a rational, national policy in this regard; and be it further

Whereas, the cost of such insurance is passed on to the public; and

RESOLVED, that if such an approach fails, The Medical Society of New Jersey urge the State Commissioner of Insurance to make available at a reasonable cost, malpractice insurance for all physicians including the mandating of such coverage by companies doing business in New Jersey.

Whereas, an increasing number of insurers are withdrawing from the market for various reasons; now therefore be it

RESOLVED, that The Medical Society of New Jersey do all within its power to assure that the

Rejected (page Tr 119)

#6

Payment of Malpractice Premiums in Installments

From the Morris County Medical Society

(Reference Committee "C")

Whereas, the premium costs for medical malpractice insurance have dramatically increased over the past two years; and

RESOLVED, that the Commissioner of Insurance be petitioned by The Medical Society of New Jersey to permit the payment of malpractice premiums in installments; and be it further

Whereas, the insurance companies require payment of all malpractice premiums in advance; and

RESOLVED, that such permission be effective immediately; and be it further

Whereas, such procedure has created, and is creating, hardships on members of the medical profession; and

RESOLVED, that a copy of this resolution be distributed to county medical societies, members of the state legislature, and the Governor of the State of New Jersey.

Whereas, the Commissioner of Insurance of the State of New Jersey permits the payment of certain other types of insurance premiums in installments; now therefore be it

Referred to the Standing Committee on Medical Defense and Insurance for study and implementation of the principle therein through negotiation with MSNJ's Insurance carrier (page Tr 119)

#7

Amendment of Medicaid Legislation

From the Passaic County Medical Society

(Reference Committee "E")

Whereas, it was the intent of Title XIX (Medicaid) to provide quality medical care for the indigent, without stigma, and to transfer this care from the clinic setting to the private office, without requiring the physician to render "charity care;" and

Whereas, restrictions have been written into that law which represent not only evidence of distrust of the physician, but result in the creation of a second-class status for the Medicaid patient, and result either in unreasonable delays in the rendering of treatment, or demand that the physician render care on a charity basis; and

Foregoing "Whereas" amended by the Reference Committee by deletion of the words "represent not only evidence of distrust of the physician, but"

Whereas, these inequities will ultimately lead to a further depletion of the availability of physicians in poverty areas; and

Whereas, The Medical Society of New Jersey recognizes that the individual physician is in the best position to determine the needs of his patients; now therefore be it

RESOLVED, that The Medical Society of New Jersey shall actively work for changes in the Ti-

tle XIX legislation and directives so as to allow a physician to be reimbursed for the additional costs of items consumed by or issued to the patient, when these items are necessary and essential to the immediate care being rendered, in addition to the customary charges for the visit; and be it further

RESOLVED, that the desire of this Society be presented to the American Medical Association for similar action so that its Council on Legislation might seek to promote these changes at the appropriate federal level; and be it further

RESOLVED, that The Medical Society of New Jersey declare its belief that quality medical care cannot be obtained by legislation which requires a dual standard of care.

Amended by the Reference Committee by deletion of the foregoing "Resolves" and insertion of the following "Resolves:"

RESOLVED, that The Medical Society of New Jersey declare its belief that quality medical care cannot be obtained by legislation which requires a dual standard of care; and be it further

RESOLVED, that The Medical Society of New Jersey shall actively work for changes in the Title XIX legislation and directives so as to allow a physician to be reimbursed for the additional costs of items consumed by or issued to the patient.

Adopted as amended by the Reference Committee (page Tr 122)

#8

Exemption from Licensure

From the Hudson County Medical Society

(Reference Committee "E")

Whereas, there is a critical shortage of physicians in New Jersey to adequately meet the needs of the community; and

Whereas, most of the hospitals of New Jersey no longer have American Medical Association approved internships; and

Whereas, the majority of the interns and residents in New Jersey hospitals are graduates of foreign medical schools; and

Whereas, these foreign graduates after their internships and residencies are often available to cover various departments of the hospitals serv-

ing as house physicians and surgeons in hospitals with or without an intern or residency program; and

Whereas, under the existing Medical Practice Act of New Jersey these qualified and well-trained physicians cannot be employed unless licensed in the State of New Jersey; now therefore be it

RESOLVED, that, in order to allow the hospitals of New Jersey better to care for their patients, the Medical Practice Act be modified to permit the State Board of Medical Examiners to grant exemption from licensure to eligible (as defined hereunder) physicians to work only in voluntary and public hospitals licensed by the

State of New Jersey and only at the specific direction and supervision of a plenary licensed physician; and be it further

RESOLVED, that exemption from licensure shall be granted annually to any eligible physician for not more than a total period of two years and only with the proof of employment in a voluntary or public hospital licensed by the State of New Jersey.

[“Eligible physicians shall be those physicians who have completed an internship (or residency) in a hospital in the United States which has been approved by the Education Council of the American Medical Association (or American Osteopathic Association).”]

Rejected with notation (page Tr 122)

#9

Federal Catastrophic Health Insurance

From the Essex County Medical Society

(Reference Committee “E”)

Whereas, serious or prolonged illness can decimate families’ finances, and the AMA recognizing this, states in its Mediredit Program that “advances in science and in medical and health-care techniques, along with inflation throughout our economy, have driven up the cost of care to the point that even a person of moderate to good income can be left economically drained or seriously in debt after a long or severe illness;” and

Whereas, renal dialysis, prohibitively expensive on a private basis, is already being financed by the government through legislation which was sponsored outside the medical profession; and

Whereas, well-planned catastrophic insurance coverage would obligate the nation’s taxpayers to help pay for care only with persons with documented catastrophic illness who have used up their insurance and other reasonable ability

to pay the costs; now therefore be it

Above “Whereas” amended by the Reference Committee by insertion in the first line of the word “Federal” after “well-planned.”

RESOLVED, that The Medical Society of New Jersey request that the American Medical Association, through resolution at its June 1975 convention, assume the leadership in the study and promotion of catastrophic health insurance, and that in so doing the AMA draft, support, and actively seek implementation of a catastrophic health-care plan, preferably as a separate legislative entity distinct from any national comprehensive health-care plan.

Foregoing “Resolved” amended by the Reference Committee to read:

RESOLVED, that The Medical Society of New Jersey request that the American Medical Association, through resolution at its June 1975 convention, assume the leadership in the study and promotion of catastrophic health insurance, and that in so doing the AMA draft, support, and actively seek implementation of an immediate plan to lessen the financial impact of catastrophic illness.

Adopted as amended by the Reference Committee (page Tr 122)

#10

Legislation Regarding Malpractice Insurance

From the Mercer County Medical Society

(Reference Committee "E")

Whereas, the cost of malpractice insurance has risen drastically in the last two years; and

Whereas, one of the principal reasons for this rate of increase has been the actuarial uncertainty created by the current statute of limitations on such suits (physicians may be sued twenty years or longer after actual incident); now therefore be it

RESOLVED, that the Mercer County Medical Society recommend to The Medical Society of New Jersey that they introduce into the legislature the following bill:

"Section I — Actions to recover damages for injuries to the person arising out of any medical or surgical treatment or operation must be brought within two (2) years from the date of the incident giving rise to the action, or within one (1) year of the date of discovery, whichever occurs last, but in no event, later than four (4) years from the date of the incident."

"Section II — This act shall take effect immediately upon becoming law."

Referred, upon recommendation of Reference Committee, to a joint committee of the Council on Legislation and the Standing Committee on Medical Defense and Insurance or a special ad hoc committee to be appointed by the President or the Board of Trustees (page Tr 123)

#11

Relicensure of Physicians

From the Hudson County Medical Society

(Reference Committee "E")

Whereas, the private practice of medicine is progressively being destroyed by an avalanche of socialistic legislation; and

Whereas, in most cases we have been advised not to be concerned because the particular inroad was only under consideration; and

Whereas, next we hear that a law has been enacted and it is too late, since it is a law and we must abide by its provisions; and

Whereas, irate demands for repeal are met by the argument that we cannot prove how ill-conceived or unconstitutional the law is until its

inadequacy has been proven in practice; and

Whereas, politicians promising improvements that could not and have not materialized have instead reduced the quality of health care and are actively creating the crisis they claim already exists; and

Whereas, our academic brethren in their zeal to push formal continuing medical education have sold the concept that we leave medical school with a bag full of knowledge from which we dispense pieces of wisdom until the bag is empty while they negate the fact that to an open mind, experience may still be the best teacher; and

Whereas, they also overlook the fact that most physicians are not opposed to taking postgraduate courses that they feel will add to their knowledge; that most of us keep well abreast of medical innovations through reading and daily formal and informal discourse with our peers; and

Whereas, the argument that we have failed in our obligation to protect the public from those among us who should not be allowed to practice gives no validity to the premise that politicians are more trustworthy or better qualified to police our profession; and

Whereas, there are more than enough laws, rules, and regulations available to rid the profession of its small number of incompetents which can only be done through *due process of law*; and

Whereas, the relicensure concept would place the physician's right to continue practicing medicine at the mercy of the often arbitrary and capricious whim of an examining authority — without recourse; now therefore be it

RESOLVED, that The Medical Society of New

Jersey actively oppose any legislation or bureaucratic regulation that would require relicensure examination of physicians.

Not adopted. Reference Committee offered the following substitute resolution:

Substitute Resolution #11
Relicensure of Physicians

Whereas, the private practice of medicine is progressively being adversely modified by legislation; and

Whereas, in most cases we have been advised not to be concerned because the particular bill was only "under consideration;" and

Whereas, our next knowledge is that this bill has been enacted and since it is now law we must abide by its provisions; and

Whereas, demands for repeal are met by the argument that we cannot prove how ill-conceived the law is until its adequacy has been proved in practice; and

Whereas, politicians promising improvements that could not and have not materialized have instead reduced the quality of health care and are actively creating the crisis they claim already exists; and

Whereas, the charge that we have failed in our obligation to protect the public from those among us who should not be allowed to practice gives no validity to the premise that politicians are better qualified to evaluate our profession; and

Whereas, there are adequate laws, rules, and regulations to rid the profession of its small number of incompetents; and

Whereas, the relicensure concept would place the physician's right to continue practicing medicine at the whim of an examining authority — without recourse; and

Whereas, MSNJ is already on record as requiring continuing medical education for continued membership; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively oppose any legislation or bureaucratic regulation that would require relicensure examination of physicians.

Substitute Resolution #11 adapted (Tr 123)

#12 Statute of Limitations

From Robert E. Jennings, M.D., Delegate, Essex County
(Reference Committee "E")

Whereas, the present Statute of Limitations in New Jersey, particularly as it affects minors, is unreasonable; and

Whereas, other states have more realistic statutes establishing more realistic time limits on liability suits; and

Whereas, legislators now are more inclined to review unfair laws concerning professional liability; now therefore be it

RESOLVED, that The Medical Society of New Jersey draft, introduce, and actively support legislation which would establish more realistic Statutes of Limitation in New Jersey.

Referred, upon recommendation of Reference Committee, to a joint committee of the Council on Legislation and the Standing Committee on Medical Defense and Insurance or a special ad hoc committee to be appointed by the President or the Board of Trustees (page Tr 123)

#13

Unlicensed Physicians in Community Hospitals

From Samuel N. Feinsod, M.D., Delegate, Essex County

(Reference Committee "E")

Whereas, it is illegal to hire physicians unlicensed in New Jersey to work as house physicians in voluntary hospitals in this State even though they are qualified, well trained, and working under the supervision of fully-licensed physicians; and

Whereas, these unlicensed physicians can be employed by State and county hospitals, thereby establishing a double standard of patient care for citizens of New Jersey; and

Whereas, we will be faced with a national medical crisis after June 30, 1975, when internship programs in voluntary hospitals will be discontinued and there will be a deficient supply of physicians; and

Whereas, nurse practitioners and paramedics are being trained to perform functions heretofore performed by physicians only, and such functions and duties are denied to unlicensed though qualified physicians; and

Whereas, this will entail at least 350 licensed

physicians which number will not be available and, if available, many will be unable to fit into the pattern of house staff physicians due to age and temperament; and

Whereas, the increased cost will probably be over two million dollars at a time when the cost of medical care is so high and many hospitals are already in financial straights; and

Whereas, many states have a law which provides a limited permit to unlicensed physicians to work in all hospitals under the supervision of licensed physicians, now therefore be it

RESOLVED, that action be taken to have a law passed in the State of New Jersey that would provide temporary or limited permits to qualified unlicensed physicians to practice medicine under the supervision of a licensed physician in community and voluntary hospitals as well as State and county hospitals.

Rejected with notation (page Tr 122)



MSNJ Staff and Guests — Clockwise from the Bottom — Mr. Cookson, Mr. Moyer, Mr. Lambert, Mrs. Lambert, Mrs. Treptow, Mr. Treptow, Mrs. Cookson.

#14

HEW Ruling Concerning Medicare and Medicaid Admissions

From the Ocean County Medical Society

(Reference Committee "F")

Whereas, the November ruling by HEW requiring certification within one working day of the necessity of all Medicare and Medicaid admissions is gross interference with the physician's freedom to practice medicine; and

Whereas, the patient's rights to care are being abridged; and

Whereas, this regulation might cause physicians of a given institution to become antagonists in judgment of an admission with the patient's welfare at stake; and

Whereas, this regulation is intended to force the

physician to act as a fiscal watchdog for HEW without compensation; and

Whereas, the AMA has endorsed the principle that no physician should be obligated or bound to serve on a bureaucratically originated committee without recompense; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge its membership not to participate in the implementation of this regulation through any utilization committee or otherwise.

Adopted (page Tr 125)

#15

New Jersey Self-Contained Area for P.L. 93-641 National Health Planning and Resources Development Act of 1974

From the Camden County Medical Society

(Reference Committee "F")

Whereas, the Department of Health, Education, and Welfare uses the Standard Metropolitan Statistical Area in this Public Law which places the Counties of Camden, Burlington, and Gloucester in the Philadelphia area, as well as Bergen County in the New York region, Warren County in the Easton, Pennsylvania region, and Salem County in the Wilmington, Delaware area; and

Whereas, the PSRO Area (Area 8), already approved by HEW is composed of the seven southern counties of the State; and

Whereas, the placement of Camden, Burlington, and Gloucester Counties under control of Philadelphia would prohibit the ongoing development of the medical school in Southern New Jersey; and

Whereas, the highest quality services including specialized services such as cardiac surgery, organ transplantation and dialysis, and radiation therapy centers are available in Southern New Jersey; and

Whereas, the capitation funds included in this law would be considerable, since the densely populated counties are involved in this reassignment and therefore some of these funds would be lost to New Jersey; and

Whereas, the experience of Southern New Jersey under the Delaware Valley Regional Medical Program has not been favorable; and

Whereas, this area of the State needs funds for the development of new services especially related to the medical school; now therefore be it

RESOLVED, that the Camden County Medical Society endorses the request for the waiver from the original law by the Governor and urges the Commissioner of Health, the federal legislators, and the state legislators to support this waiver; and be it further

First Resolved amended by the Reference Committee to read:

RESOLVED, that The Medical Society of New Jersey endorse the request for the waiver from the original law by the Governor and urge the Commissioner of Health, the federal legislators, and the state legislators to support this waiver; and be it further

RESOLVED, that this resolution be presented to the House of Delegates of The Medical Society of New Jersey for its concurrence and that it instruct its American Medical Association Delegates to introduce a resolution in its House urging the integrity of state boundaries under P.L. 93-641.

Adapted as amended by the Reference Committee (page Tr 125)



House of Delegates — Third Session, June 2, 1975

#16 Reimbursement to Physicians for Performing Utilization Review Functions

From the Hudson County Medical Society
(Reference Committee "F")

Whereas, physicians in New Jersey have been rendering valuable service on hospital utilization review committees without compensation for many years; and

Whereas, the PSRO legislation and the new regulations (November 29, 1974) will place increasing burdens of time and diligence on the physician members of a utilization review committee; and

Whereas, effective utilization review is expected to reduce costs of institutional care; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as actively supporting the principle that physicians should be reimbursed for their time devoted to utilization review; and be it further

RESOLVED, that this action of The Medical Society of New Jersey be made known to all third parties which benefit from physician participation in utilization review.

Adapted (page Tr 125)

#17 Updating Medicare Fees

From the Morris County Medical Society
(Reference Committee "F")

Whereas, at the present time it takes eighteen months from the date "of notification" to the fiscal intermediary to update Medicare payment schedules; and

Whereas, all other health services have a much shorter time in which to increase their fees; and

Whereas, eighteen months is an excessively long time, when the cost of living increases almost daily; now therefore be it

RESOLVED, that The Medical Society of New Jersey institute a study, and make recommendations to the Department of Health, Education, and Welfare for changes in Medicare legislation to permit fee allowance changes in a more expeditious and timely fashion.

Faregoing "Resolved" amended by changing final period to a comma and adding the words "and that the carrier ask the appropriate Federal agency to inform the public of such changes."

Adopted as amended by the House (page Tr 123)

#18 Rubella Vaccination

From the Monmouth County Medical Society
(Reference Committee "G")

Whereas, several states have adopted legislation requiring premarital rubella serological testing; and

Whereas, rubella vaccination is an effective method for the prevention of rubella tetrogenic complications with serological testing for rubella antibodies a useful adjuvant; now therefore be it

RESOLVED, that The Medical Society of New Jersey primarily and strongly advocate rubella vaccination as a requirement for admission to any school in New Jersey.

Rejected (page Tr 127)

#19 Smoking

From the Union County Medical Society
(Reference Committee "G")

RESOLVED, that smoking of any material shall be prohibited in all deliberative meetings of all official bodies connected with The Medical

Society of New Jersey.

Adopted (page Tr 127)

#20 Annual Reports

From the Board of Trustees

(Reference Committee "H")

Whereas, many of the reports submitted to the House of Delegates at the annual meeting are merely narratives of activity containing neither recommendations nor substantive matter of import to the membership; and

Whereas, the function of the House of Delegates and the interests of the membership would be better spent on consideration of resolutions and specific action items; and

Whereas, the curtailment of such a practice can produce savings in printing, preparation, and distribution costs; now therefore be it

RESOLVED, that only those reports required by the Constitution and Bylaws, those requesting action of the House; and those requested by the House for its information be distributed for consideration at annual meetings.

Rejected (page Tr 128)



Newly elected Second Vice President and Mrs. Charles S. Krueger

#21 Definition of a Specialist

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, there has been some confusion in the past in the minds of the public regarding the definition of a specialist in medical practice; now therefore be it

RESOLVED, that The Medical Society of New Jersey adopt the following definition:

A specialist is a fully-licensed physician who limits his practice to his specialty and who:

(1) Is a diplomate of the appropriate American Board, or

(2) Is a fellow of the appropriate American Specialty College, or

(3) Has been notified of his admissibility to examination by the appropriate American Board for a period of five years thereafter, or

(4) Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges.

Withdrawn by sponsor with concurrence of the House (page Tr 116)

#22

Reaffirmation of Traditional Principles of Ethical Medical Practice

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, the practice of acupuncture has recently become widely available and newsworthy; and

Whereas, it is the duty of the Bergen County Medical Society to advise the public on matters of health; now therefore be it

RESOLVED, that the following traditional principles of ethical medical practice be reaffirmed:

(1) A physician shall practice a method of healing which is founded on a scientific basis. This requires appropriate physical examination,

laboratory and other diagnostic procedures in order to establish a diagnosis prior to treatment.

(2) To employ methods of therapy which are not based on the accumulated knowledge in medicine can only be accepted as ethical if carried out under a systematic program of scientific methods competently designed under accepted standards with the informed consent of the patient.

(3) The concept of acupuncture per se is neither approved nor condemned at this time.

Adopted (page Tr 116)

#23

Study Regarding Self-Insured Malpractice Program

From the Bergen County Medical Society

(Reference Committee "C")

Whereas, the continuation of liability insurance by commercial carriers is frequently unreliable; and

Whereas, the practicing physician has no recourse when premium rates or conditions of the policies are abruptly and irrationally changed; and

Whereas, cancellation of the policy may occur without prior notice to the physician and without acceptable notice of termination; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish an ad hoc committee empowered thoroughly to investigate limitations to insurance with commercial carriers. Particular

emphasis will be placed upon "as insured" by The Medical Society of New Jersey membership; and be it further

Reference Committee amended the above "Resolved" to read:

RESOLVED, that The Medical Society of New Jersey investigate alternatives with commercial carriers. Particular emphasis will be placed upon self insurance by The Medical Society of New Jersey membership.

RESOLVED, that the committee be empowered to disburse the funds necessary for this purpose and to present its findings to the House of Delegates at a special session no later than September 1975.

The foregoing "Resolved" deleted upon recommendation of Reference Committee.

Adopted as amended by the Reference Committee and referred to Standing Committee on Medical Defense and Insurance (Tr 119)

#24

Malpractice Law Revision

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the malpractice crisis has reached proportions that will lead to disaster for the medical profession unless legislative relief is obtained; now therefore be it

RESOLVED, that The Medical Society of New Jersey use its influence to obtain a legislative program that calls for the following:

1. Establishment of an alternative to the present jury system for review of malpractice cases and decisions on awards;
2. Restriction of the statute of limitations to no more than three years from the date of occurrence and no more than six years in cases involving minors;
3. Removal of the doctrine of *res ipsa loquitur*;
4. Dollar claims and awards should be held in confidence and not published in the news media;
5. Lack of informed consent to be abolished as grounds for malpractice cases except in cosmetic

and experimental procedures;

6. No duplication of indemnification in malpractice awards for patient's loss of income when such loss is partially or wholly reimbursed by other insurance policies or unemployment compensation;

7. Obtain a legal definition of malpractice as "that which is deviant from the usual standards in the community in which it is performed." In order to win a claim they would have to prove such deviation and show that deviation related directly in injuries that would not have occurred otherwise;

8. Attorney's fees to be set on a sliding scale with a decreasing percentage as the amount of the award increases.

Upon recommendation of the Reference Committee, referred to a joint committee of the Council on Legislation and the Standing Committee on Medical Defense and Insurance or a special ad hoc committee to be appointed by the President or the Board of Trustees (page Tr 123)



Executive Director Emeritus Richard I. Nevin



and Mrs. Nevin

#25

Non-Smoking in Enclosed Public Places

From the Bergen County Medical Society

(Reference Committee "G")

Whereas, from a health standpoint, non-smokers in enclosed public places are as much in danger from tobacco fumes as are smokers themselves; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the New Jersey Legislature to pass a law whereby the rights of non-smokers will be protected in all covered places where the public gathers; and be it further

RESOLVED, that such places as theaters, in-

door arenas, elevators, street cars, buses, planes, passenger aircraft, and all other public gathering places should be restricted as to smoking areas; and be it further

The Reference Committee amended the second "Resolved" by adding the word "enclosed" preceding the word "public."

RESOLVED, that designated restricted areas be provided for the smoking public in such enclosed public places.

Adopted as amended by the Reference Committee (page Tr 127)

#26

School Child Bus Safety

From the Bergen County Medical Society

(Reference Committee "G")

Whereas, members of the Bergen County Medical Society are deeply disturbed by the continued lack of safety in the construction of school buses, specifically with regard to:

(1) Inadequate body structure, and

(2) Inadequate seating — with lack of restraints, insufficient seat anchorage, insufficient padding, and inadequate seat back height; and

Whereas, the Bergen County Medical Society, in association with other professional groups, has urged reform first through Department of Education rule and regulation, but without success, and thereafter through support of

legislative action, also without success; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as urging in the strongest possible terms immediate and forceful action by Governor Brendan T. Byrne to implement at once these recommendations of The Medical Society of New Jersey in these child-related safety matters.

Reference Committee amended the "Resolved" to read as follows:

RESOLVED, that The Medical Society of New Jersey go on record as urging in the strongest possible terms immediate and forceful action by Governor Brendan T. Byrne to correct these inadequacies and to implement at once Resolution #17, dated May 20, 1969, in these child-related safety matters.

Adopted as amended by the Reference Committee (page Tr 127)

#27

Teenage Alcohol Education

From the Bergen County Medical Society

(Reference Committee "G")

Whereas, the abuse of alcohol among teenagers is rapidly increasing to the extent that an unofficial estimate is, that between 300,000 to one-half million teenagers have the disease of alcoholism; and

Whereas, there is evidence that alcoholism is spreading in epidemic proportion among our youth, and 5 per cent of the students between the seventh and twelfth grades are estimated to have an alcoholism problem; and

Whereas, parental drinking patterns relate directly to drinking patterns of youth; and

Whereas, family physicians are in a unique position as advisor to both families and students; and

Whereas, it is known that the disease of alcoholism leads to unhappiness and often

tragedy; now therefore be it

RESOLVED, that our organization, at the county, state, and national level, encourage, supervise, coordinate, and support programs, in cooperation with parents and the schools, which will arrest or alleviate this growing problem; and be it further

RESOLVED, that the school physicians in our ranks undertake a survey of the extent of the problem in their respective schools and intensify alcoholism education programs through lectures, films, and student and parent group discussions.

Reference Committee amended the foregoing "Resolved" by adding the words "and local school boards" following the word "ranks."

Adopted as amended by the Reference Committee (page Tr 127)

#28

Hospital Application Forms for Present and New Staff Members

From the Union County Medical Society

(Reference Committee "F")

Whereas, several hospitals in New Jersey have recently mandated the completion of a new application form for medical staff membership by present staff members as well as by new applicants; and

Whereas, the rationale for this new mandatory procedure is that it is a requirement of the Joint Commission on Accreditation of Hospitals; but no definitive proof of such a requirement has ever been presented; and

Whereas, inspectors from the Joint Commission on Accreditation of Hospitals are on record as stating that they personally see nothing wrong with such applications, have urged that they be used, and have suggested that staff physicians sign them; and

Whereas, such applications go to the extreme in the precise delineation of all staff privileges; and

Whereas, such applications grant to hospital ad-

ministrators and/or members of medical staffs the privilege and authority to consult with administrators and members of medical staffs of other hospitals and institutions with which the applicant has been associated, and further to consult with "others" including past and present malpractice carriers with regard to professional competence, character, and ethical qualifications; and

Whereas, such applications authorize the hospital, its medical staff, and/or its representatives to inspect all records and documents, including medical records at other hospitals, and further exempts and releases from all liability all representatives of the hospital to which application is being made for their acts performed in good faith and without malice; and

Whereas, the very language of such applications is a reflection on the character and integrity of physicians who have served such hospitals well and faithfully over the years, and have given unstintedly of their time, effort, skill and goods, for

the purpose of elevating hospital standards, supervising and training house staff members, building new structures and alleviating the suffering of all patients regardless of their ability to pay; now therefore be it

Amended by Reference Committee by deleting the words "now therefore be it" at the end of final "whereas," inserting the word "and" after the semi-colon, and adding the following:

"Whereas, such applications constitute a direct invasion of the physician's privacy; now therefore be it

RESOLVED, that The Medical Society of New Jersey record itself as opposing the use and implementation of such applications; and be it further

RESOLVED, that The Medical Society of New Jersey instruct its Delegates to the American Medical Association to present this resolution in proper form to the AMA House of Delegates in June, 1975, for its consideration and action.

Adopted as amended by the Reference Committee (page Tr 123)

#29

National Health Resources Planning and Development Act of 1974

From the Board of Trustees

(Reference Committee "F")

Whereas, the Secretary of HEW, pursuant to authority granted to him under the National Health Resources Planning and Development Act of 1974, has tentatively designated the Standard Metropolitan Statistical Areas as new planning regions; and

Whereas, such a designation removes six of the twenty one New Jersey counties from New Jersey State control and places them in other jurisdictions; and

Whereas, this designation defies orderly planning and is detrimental to current health service

delivery systems presently operative in New Jersey, and consequently poses a hazard to the health and well being of a large number of New Jersey residents; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey urge the AMA to do all within its power to assure that health service areas under this law remain within the geographic boundaries of the respective states unless the affected states have voluntarily waived jurisdiction.

Adopted (page Tr 123)

#30

Payment by Blue Shield for Medical Consultation in Consultant's Office

From the Union County Medical Society

(Reference Committee "F")

Whereas, Resolution #11, "Payment by Blue Shield for Medical Consultation in Consultant's Office," had the benefit of extensive deliberation in Reference Committee "C" and the general concurrence by representatives of the Medical-Surgical Plan of New Jersey at Reference Committee "C," and was referred to the Council on Medical Services at the 1974 Annual Meeting of The Medical Society of New Jersey; and

Whereas, Vincent A. Maressa, the Executive Director of The Medical Society of New Jersey, has reported to the Council on Medical Services that he was unable to reach agreement on implementing this resolution with officials of the Medical-Surgical Plan of New Jersey; and

Whereas, the Medical-Surgical Plan of New Jersey has stated that in order to implement this resolution the plan contract would have to be amended, that such change in the contract would

discriminate against patients whose abnormalities were brought to light by other than PAT, and that such payment for office consultations would result in substantial premium increase; and

Whereas, the reasons given by officials of the Medical-Surgical Plan of New Jersey are unilateral and unsatisfactory; now therefore be it

RESOLVED, that Resolution #11, of the 1974 Annual Meeting, "Payment by Blue Shield for Medical Consultation in Consultant's Office" be resubmitted to the House of Delegates and that the House of Delegates urge the Council on Medical Services and the Executive Director of The Medical Society of New Jersey to renegotiate this matter with the Medical-Surgical Plan of New Jersey.

Rejected with notation (page Tr 126)

#31

Utilization Review Position

From the Board of Trustees

(Reference Committee "F")

Whereas, peer review and utilization review have been traditionally performed by the medical profession to assure quality medical care and not pure cost control; and

Whereas, this type of review is best handled on a local level; and

Whereas, any nationwide method of utilization review must necessarily ignore such local problems and cannot be accurately varied according to the size of hospital facility and

medical staff; and

Whereas, any such national scheme will result only in a rationing of health care services to patients; now therefore be it

RESOLVED, that The Medical Society of New Jersey vigorously support the AMA's lawsuit against the Utilization Review Regulations proposed by HEW to be implemented July 1.

Adopted (page Tr 126)

#32

Federal Regulations Mandating Hospital Utilization or Peer Review Procedures

From Howard D. Slobodien, M.D., Delegate, Middlesex County)

(Reference Committee "F")

RESOLVED, that federal regulations mandating hospital utilization or peer review procedures be applied uniformly to all hospitals, including city, county, state, public health, and VA hospitals; and be it further

RESOLVED, that this resolution be introduced at the AMA convention for adoption and action.

Adopted (page Tr 126)

#33

Malpractice Legislation

From the Burlington County Medical Society

(Reference Committee "E")

Whereas, the number and cost of malpractice claims within the United States and New Jersey have increased to the point that a "malpractice crisis" exists, which has increased malpractice insurance rates to physicians within New Jersey to alarming proportions; and

Whereas, the increase in cost of malpractice insurance to some specialists in New Jersey has caused some of them to leave the state, or in some cases to leave the practice of medicine entirely; and

Whereas, recent legal decisions have shown a trend toward social compensation for injuries and/or untoward results not the result of malpractice, in addition to the recovery for malpractice; now therefore be it

hold office for five years. All claims against physicians, hospitals, nurses, and paramedical personnel would be taken before the Board unless the patient, prior to treatment, specifically rejected the Board procedure. The Board would establish attorneys' fees per case in addition to limits of patient compensation.

2. A \$100,000 ceiling on damages against individual physicians would be established, for each injury occurrence. However, a supplementary "catastrophic fund" would be formed by the State of New Jersey to award compensation for severely injured patients, whether malpractice was judged present or not, in those cases in which damages exceeding \$100,000 were established by the Patient Compensation Board.

RESOLVED, that The Medical Society of New Jersey recommend enactment of the following legislation in the State of New Jersey:

1. A Patient Compensation Board would be appointed by the Governor of the State of New Jersey with consent of the State Senate, consisting of six full-time members: two physicians, two attorneys, and two laymen. Members would

3. A statute of limitations would be established of two years from the time of occurrence of the injury in adults. However, a period of one additional year would be established in the event of late discovery of the damage or injury.

4. The State of New Jersey would form an "at risk" insurance mechanism to provide malpractice insurance for those physicians refused

medical malpractice insurance by private companies. The form would be similar to that utilized by the State of New Jersey for "uninsured motorist" coverage.

5. In cases of willful or wanton misconduct by the physician, following adjudication of the case, the Patient Compensation Board would refer the case together with recommendations to the State Board of Medical Examiners for possible disciplinary action. The revenues from all medical

license fees would be returned to the State Board of Medical Examiners so that it might hire the necessary investigators and attorneys to enforce effectively the Medical Malpractice Act and discover incompetent practitioners.

Upon recommendation of the Reference Committee, Resolution was referred to a joint committee of the Council on Legislation and the Standing Committee on Medical Defense and Insurance or a special ad hoc committee to be appointed by the President or the Board of Trustees (page Tr 123)

#34

The Counterclaim in Malpractice Litigation

From Adolph R. Wichman, M.D., Delegate, Morris County

(Reference Committee "C")

Whereas, the premium costs for medical malpractice insurance have dramatically increased over the past few years; and

Whereas, these costs are actually resulting in physicians leaving the State of New Jersey and discouraging new physicians from entering into practice in the State of New Jersey; and

Whereas, it is recognized that some studies are currently being made into areas of no-fault plans, workmen's compensation type formats, compulsory arbitration mechanisms together with the abolition of the contingency fee structure; and

Whereas, while these may be ideal solutions, we cannot await the finality to these proposals; and

Whereas, New Jersey physicians continue to battle this cataclysmic problem defensively, in attempting to find more and bigger dollar pools to fight the onslaught of this extremely unilateral and practically defenseless suit craze; and

Whereas, this problem has reached the point where the very basis of medical practice in our State and indeed our country is in jeopardy; now therefore be it

RESOLVED, that The Medical Society of New Jersey make available to its membership a mechanism whereby monies be stipulated for countersuit against the plaintiff, if the latter's suit has been judged not only defensible, but also

considered to be in the realm of "abuse of process;" this judgement to be made by the local county medical defense and insurance committee with the concurrence of its state counterpart. (The state committee adding legal and consumer representation); and be it further

RESOLVED, that there be available through the above fund legal representation to initiate such countersuits; and be it further

RESOLVED, that if countersuit is discouraged and the doctor defendant "wins" his malpractice suit, he will then be supported and represented both financially and legally by the above, to initiate full action against the plaintiff for malicious suit with emphasis on the usurping the doctrine of due process. An offensive mechanism (rather than defensive) is long overdue in dealing with these nightmarish suits; it behooves our membership to adopt this format to alert the plaintiffs of their liabilities and responsibilities and thus discourage many nuisance and specious suits; and be it further

RESOLVED, that with this seemingly simple offensive approach to withstand, at least temporarily, the onslaught of the ambitious of those members of the legal profession who find the physicians easy game will effect consideration of the true merits of a case before institution of a malpractice action.

Referred to the Standing Committee on Medical Defense and Insurance, upon recommendation of the Reference Committee (page Tr 119)

Professional Liability Insurance Crisis

Whereas, The Medical Society of New Jersey recognizes an impending professional liability insurance crisis in New Jersey which will produce an awesome financial burden on the people of New Jersey; and

Whereas, the major reason for these developments has been the constant erosion of common law principles and enacted statutes by judicial interpretation; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Governor and the Legislature of New Jersey to enact reasonable and effective remedial legislation; and be it further

RESOLVED, that The Medical Society of New Jersey urge the Courts of New Jersey to adopt a rational approach in deciding medical liability

cases and in effecting rules of court; and be it further

RESOLVED, that if the above measures are not effected within six months the physicians of New Jersey be urged to withhold all but emergency medical services and that a special session of the House of Delegates be convened to reassess this position and the implementation of these recommendations; and be it further

RESOLVED, that the President of The Medical Society of New Jersey and the Board of Trustees formulate a plan utilizing the Council on Public Relations and the Council on Medical Services to inform the public of our position and the physician members of our anticipated action.

Adopted by the House without reference to committee.



President-Elect and Mrs. McGuire and President and Mrs. Rogers



Dr. and Mrs. McGuire and their Family — Inaugural Reception

REFERENCE COMMITTEES

Reference Committee on Constitution and Bylaws

Robert Brill, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Saturday, May 31, 1975, with all members present: Doctors Richard B. Berlin, Clifford B. Blasi, Reynold E. Burch, Paul H. Pettit, Frank J. Malta (alternate), and the chairman. Approximately 10 delegates and members were present to discuss the various items under consideration.

Revision of Constitution and Bylaws (page Tr 49)

Proposed Amendments to the Constitution

a. Article IX — Officers, Section 1 — Term of Office (page Tr 49)

The Committee **recommends** that the amend-

ment be accepted.

Adopted

b. Article XII — Amendments to the Constitution (page Tr 50)

The Committee **recommends** that the amendment be accepted.

Adopted

The Committee **recommends** that the report of the Standing Committee on Revision of Constitution and Bylaws be filed.

Adopted

Reference Committee "A"

Josiah C. McCracken, Jr., M.D., Chairman

Reference Committee "A" met on Saturday, May 31, 1975, with all members present: Doctors H. Oliver Brown, Edward Foord, Warren H. Knauer, Frank A. Wolf, Samuel Bernson (alternate), and the chairman. Approximately 60 delegates and members were present to discuss the various items under consideration.

1. President (page Tr 5)

The Committee **recommends** that the report be filed.

Adopted

2. Board of Trustees (page Tr 16)

The introductory portion of this report, covering the general activities of the Board, was reviewed

and approved.

The Committee **recommends** that this portion of the report be filed.

Adopted

a. AMA Delegation (page Tr 16)

The Committee **recommends** that the report be filed.

Adopted

b. AMA Financial Crisis (page Tr 16)

The Committee **recommends** that the report be filed.

Adopted

c. Establishment of a Physicians' Bill of Rights (page Tr 16)

The Committee recommends that the report be filed.

Adopted

d. MSNJ Board Meetings — Invited Guests (page Tr 17)

The Committee recommends that the report be filed.

Adopted

e. New Jersey Hospital Association (page Tr 17)

The Committee recommends that the report be filed.

Adopted

f. Special Committee on Long Range Planning and Development (page Tr 17)

The Committee recommends that the report be filed.

Adopted

g. State Board of Medical Examiners (page Tr 18)

The Committee recommends that the report be filed.

Adopted

h. Unified AMA Membership (page Tr 18)

The Committee recommends that the report be filed.

Adopted

3. Secretary (page Tr 7)

The Committee recommends that the report be filed.

Adopted

4. Judicial Council (page Tr 24)

The Committee recommends that the report be filed.

Adopted

5. Executive Director (page Tr 27)

The Committee recommends that the report be filed.

Adopted

6. Credentials (page Tr 31)

The Committee recommends that the report be filed.

Adopted

7. Resolutions:

a. AMA Issues Workshop — Resolution #1 (page Tr 93)

There was considerable discussion as to the exact details of this proposal. The Committee approved the intent of direct communication.

The Committee recommends that the words "each year" appearing on line 13 be deleted and that the words "for a one-year trial period" be inserted. The "Resolved" would thus read:

RESOLVED, that a special workshop meeting for the above-stated purposes be set up *for a one-year trial period* as an integral part of the meeting program of MSNJ's annual meeting.

Adopted

The Committee further recommends that this Resolution be referred to the Standing Committee on Annual Meeting for implementation.

Adopted

The Committee recommends that Resolution #1 be adopted as amended.

Adopted as amended by the Reference Committee

b. Conflict of Interest on the Part of Members of the Board of Trustees and Officers of The Medical Society of New Jersey — Resolution #2 (page Tr 93)

The Committee heard many members present their views. The following portion of the annual report of the Judicial Council in this regard was read and is emphasized:

"Officers and trustees who find themselves subject to conflicting loyalties may tend to abstain on issues in which they might be subject to the charge of 'conflict of interest.' The decision not to vote on such a measure is tantamount to an admission of inability to act unequivocally on behalf of the medical profession and is not to be condoned. Therefore, officers and trustees who find themselves subject to conflicting loyalties should resign from one or the other position in order to avoid equivocation.

"The Nominating Committee must carefully scrutinize all candidates for office and screen out those whose positions could present potential for conflict."

The Committee recommends that Resolution #2 be rejected.

Adopted

c. Repeal Earnings Test for Social Security — Resolution #3 (page Tr 94)

The Committee recommends that Resolution #3

be adopted.

Adopted

d. Definition of a Specialist — Resolution #21 (page Tr 104)

The Committee recommends that part (4) of the "Resolved" be amended to read as follows:

(4) Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved by the Joint Commission on Accreditation of Hospitals.

The Committee recommends that Resolution #21 be adopted as amended.

Resolution withdrawn by the sponsor with concurrence of the House.

e. Reaffirmation of Traditional Principles of Ethical Medical Practice — Resolution #22 (page Tr 105)

The Committee recommends that Resolution #22 be rejected.

Not Adopted

Resolution #22 adopted by the House.

Reference Committee "B"

Frank Y. Watson, M.D., Chairman

Reference Committee "B" met on Saturday, May 31, 1975, with all members present: Doctors James E. Brennan, Victor H. Boogdanian, Howard H. Lehr, Raymond A. McCormack, Jr., Donald A. McLean (alternate), and the chairman. Approximately 50 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees (page Tr 18)

Evaluation of the New Jersey Foundation for Health Care Evaluation (page Tr 18)

The Committee concurs with the Board of Trustees that the current relationship between MSNJ and the Foundation is desirable and should be continued. The Committee is pleased to note that the Foundation is financially solvent and has requested no financial support from MSNJ for the coming year. Further, the Committee feels that should the Foundation request supplemental funding by MSNJ in the future, the method by which such funding is accomplished should be determined at that time rather than stipulating now that "if supplemental funding by MSNJ becomes necessary, such

funding should be made a part of the dues structure of the Society."

With these comments being made a part of the record, the Committee **recommends** that the report be filed.

Adopted

2. Treasurer (page Tr 8)

The Committee **recommends** that the Treasurer's report be filed and that commendation and special thanks be extended to Dr. Samuel J. Lloyd for a job well done.

Adopted by acclamation

3. Finance and Budget (page Tr 32)

The Committee **recommends** that the recommendations on pages Tr 33-34 of the annual report be approved.

Adopted

The Committee **recommends** that the report of the Committee on Finance and Budget be filed and that commendation and special thanks be extended to Doctor David Eckstein and his Committee for a job well done.

Adopted by acclamation

4. New Jersey Foundation for Health Care Evaluation (page Tr 86) and Supplement (page Tr 89)

Inasmuch as the New Jersey Foundation for Health Care Evaluation carries on a variety of activities funded from different sources including MSNJ, the Federal Government, and other sources, the Committee found that limiting the financial report only to the Foundation account (MSNJ special assessment) led to confusion and misunderstanding in regard to the overall activities of the Foundation.

The Committee, therefore, **recommends** that, in the future, the financial report of the Foundation to MSNJ include a report of all of the accounts of the Foundation.

Adopted

The Committee **recommends** that the report and the supplemental report be filed.

Adopted

5. Medical Student Loan Fund (page Tr 46)

The Reference Committee notes that the Medical Student Loan Fund Committee, under the chairmanship of Dr. William Greifinger, is providing the maximum assistance to the largest number of students consistent with sound management of the fund, and commends the Committee for its fine work.

The Committee **recommends** that the recommendations on page 6 of the annual report be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

6. Physicians' Relief Fund (page Tr 74)

The Committee **recommends** that the recommendations contained in the annual report be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

7. Publication (Page Tr 49)

The Committee **recommends** that the report be filed.

Adopted

8. Resolution

Funding for the New Jersey Foundation for Health Care Evaluation — Resolution #4 (page Tr 94)

In testimony before the Committee, representatives of the Foundation reported that the Foundation has received financial support from HEW for the operation of the PSRO Support Center, and from MSNJ and other sources for its other activities that have been approved by MSNJ through actions of the House of Delegates and the Board of Trustees. At the present time funding is adequate and no funds are being requested from MSNJ.

The Reference Committee therefore has amended Resolution #4 as follows: (italics indicate Reference Committee amendments)

Whereas, the New Jersey Foundation for Health Care Evaluation has received substantial funds from the Federal Government *for the operation*

of the PSRO Support Center; and

Whereas, the Foundation has adequate funds for the conduct of its MSNJ activities; and

Whereas, the Foundation has requested no additional funds from MSNJ for the fiscal year 1975-76; now therefore be it

RESOLVED, that no additional money from MSNJ be given to the New Jersey Foundation for Health Care Evaluation *at this time.*

The Committee **recommends** that Resolution #4 be adopted as amended.

Adopted as amended by The Reference Committee.

Reference Committee "C"

Andrew G. Hudacek, M.D., Chairman

Reference Committee "C" met on Sunday, June 1, 1975, with all members present: Doctors William A. Dwyer, Jr., Elmer L. Grimes, Gustav L. Ibranyi, Walter G. Scheuerman, Joseph A. Cipolla (alternate), and the chairman. Approximately 69 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

MSP Board of Trustees Nominations (page Tr 23)

The Committee **recommends** that the supplemental report containing the names of nominees to the Board of Trustees of the Medical-Surgical Plan of New Jersey be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

2. Medical-Surgical Plan of New Jersey (page Tr 78)

The Committee **recommends** that the report be filed.

Adopted

3. Medical Defense and Insurance (pages Tr 36 and Tr 43)

The Committee **recommends** that the recommendations on pages Tr 40 and Tr 41 of the annual report be approved.

Adopted

The Committee **recommends** amendment by the following recommendation to be added under "Remedial Legislation" in the supplemental report (page Tr 43):

Recommendation

That The Medical Society of New Jersey actively seek the cooperation of the State Supreme Court making mandatory use of Supreme Court

Panels under Rule 4:21 which now exist in the State for investigating professional liability insurance claims.

Adapted as amended by the Reference Committee

The Committee **recommends** that the other recommendations (page Tr 43) in the supplemental report be approved.

Adapted

The Committee **recommends** that the annual and supplemental reports be filed.

Adapted

4. Retirement Plan for Physicians (page Tr 74)

The Committee **recommends** that the report be filed.

Adapted

5. Resolutions:

a. Malpractice Insurance — Resolution #5 (page Tr 95)

Both the federal government and the AMA have determined that this problem must be solved on the state level. Additionally, S-3232 recently introduced in New Jersey adequately assures the availability of insurance.

The Committee **recommends** that Resolution #5 be rejected.

Adapted

b. Payment of Malpractice Premiums in Installments — Resolution #6 (page Tr 95)

The Committee **recommends** that Resolution #6 be referred to the Committee on Medical Defense and Insurance for study and implementation of the principle therein through negotiation with our insurance carrier.

Adapted

c. Study Regarding Self-Insured Malpractice Program — Resolution #23 (page Tr 105)

The Committee **recommends** that the second Resolved be eliminated and the first Resolved be amended as follows:

“RESOLVED, that The Medical Society of New Jersey investigate alternatives with commercial carriers. Particular emphasis will be placed upon self-insurance by The Medical Society of New Jersey membership.”

Adapted

The committee **recommends** that Resolution #23 be adopted and referred to the Committee on Medical Defense and Insurance as amended.

Adapted as amended by The Reference Committee

d. Counterclaim in Malpractice Litigation — Resolution #34 (page Tr 112)

Because of the costly and practical problems presented herein and the fact that MSNJ is currently pursuing another approach, the Committee **recommends** that Resolution #34 be referred to the Committee on Medical Defense and Insurance for study and report to the Board of Trustees.

Adopted

Additional Legislative Approaches

The Committee's attention was directed to Resolution #24 which was adopted in 1971. That Resolution suggested several legislative measures which were not introduced because of lack of willingness on the part of the Legislature.

The Committee **recommends** that The Medical Society of New Jersey seek the introduction and passage of the proposals drafted pursuant to Resolution #24 of the 1971 House of Delegates.

House amended the last line of the above to read:

Resolution #13 of the 1974 House of Delegates

Adapted as amended by the House.

Minority Report

Re: The Medical Defense and Insurance Committee Supplemental Report on Professional Liability — Section One

Submitted by Walter Scheuerman, M.D. — Member of Reference Committee "C"

On May 28, 1975, an emergency meeting was called at the request of the Joseph A. Britton Agency who met with the Committee on Medical Defense and Insurance to recommend and approve new rate increases for professional liability for The Medical Society of New Jersey. Their decisions were not available to the delegates until May 31, 1975, at 2 p.m. On June 1, 1975, at Reference Committee "C" the following rates were approved:

Increase in limits factor	24.3%
Additional increase	23.7%
Total	48 %

Last year with the large increase in premium, a special category was created for orthopedic and

neurosurgeons. In an effort to hold the premiums of the other categories to a minimum increase, the neurosurgeon increase was set at 200 percent, making a total yearly premium of \$14,110 for \$1 million policy limits. With the present recommended increase of 48 percent next year, the 48 neurosurgeons in the State of New Jersey will be asked to pay a prohibitive premium of \$20,882 for this coverage. It should be noted that no other insurance carrier now writes malpractice insurance and therefore a monopoly exists so that risks can be spread without competitive interference of other insurance companies taking the lower risks specialty categories.

If this 48 percent increase across the board is to stand approved by the House of Delegates to include neurosurgeons, this leaves the neurosurgeons in a crisis situation. We appeal to the delegates that the present across-the-board increase of 48 percent exclude neurosurgeons and that their present insurance yearly premium of \$14,110 be maintained.

Not Adopted

Reference Committee "D"

Frederick J. Knocke, M.D., Chairman

Reference Committee "D" met on Saturday, May 31, 1975, with all members present: Doctors Alfonse A. Cinotti, Ralph J. Lewis, Robert L. Maggs, John S. Van Mater, Francis X. Keeley (alternate), and the chairman. Approximately 36 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

a. Countersigning of House Officers' Hospital Orders and Temporary Limited Licensure (page Tr 19)

The Committee considered the Board of Trustees' report on the "countersigning of House Officers' Hospital Orders and Temporary Limited Licensure." There was extended discussion from the floor relative to this issue.

The Committee **recommends** that the Board of Trustees of The Medical Society of New Jersey continue its efforts to bring about a ruling by the State Board of Medical Examiners providing a temporary certification, to carry on all the functions of the physicians in the hospital setting, to house staff in AMA-approved residencies for the first eighteen months of their training, after which they would be expected to become regularly licensed.

Adopted

The Committee **recommends** that the report be filed.

Adopted

b. Health Manpower Report on Physicians (page Tr 20)

The Committee **recommends** that the report be filed.

Adopted

c. **Opposition to the Opening of a School of Osteopathy in Southern New Jersey** (page Tr 20)

The Committee **recommends** that the report be filed.

Adopted

2. **Medical Education** (page Tr 44)

The Committee **recommends** that the report be filed.

Adopted

3. **Emergency Medical Care** (page Tr 72)

The Committee **recommends** that the recommendation on page Tr 73 of the annual

report be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

4. **Medicine and Religion** (page Tr 73)

The Committee **recommends** that the report be filed.

Adopted

Dr. Stanley Bergen expressed the appreciation of the College of Medicine and Dentistry of New Jersey for the cooperation extended to the College by The Medical Society of New Jersey. The Committee expressed to Dr. Bergen appreciation of the Society for the cooperation that they in turn had received from the College.

Reference Committee "E"

Robert H. Areson, M.D., Chairman

Reference Committee "E" met on Sunday, June 1, 1975, with all members present: Doctors Armando F. Goracci, Edward P. Healey, Nicholas E. Marchione, Kenneth A. Morrissey, Jerome A. Dolan (alternate), and the chairman. Approximately 40 delegates and members were present to discuss the various items under consideration.

1. **Legislation** (page Tr 52) and supplementals #1 and #2 (pages Tr 56 and Tr 59)

The Committee **recommends** that the reports be filed.

Adopted

The Committee noted the tremendous amount of work done by the Council and commends it for its sincere efforts. The Committee feels that consideration must be given to provide further administrative support for the Council.

It became apparent at the Reference Committee hearing that there was inadequate communication between the Council and membership of The Medical Society of New Jersey. Members should be advised that information is continually available relative to Council actions via: (a) *The Journal*; (b) the *Membership Newsletter*; (c) direct written reports to each county secretary and/or executive officer. It should also be noted that representation at Council meetings is

strongly urged and requested from: (a) each county medical society, and (b) each specialty society. Dates of Council meetings should be provided to these organizations.

The Reference Committee suggests that the Council in the future provide information to the House relative to: (a) the current status of bills receiving MSNJ "active support" and/or "active opposition;" (b) a biennial report (concurrent with the legislative session) to detail the actions of our state legislature on bills actively supported and/or actively opposed.

2. Public Relations (page Tr 70)

The Committee **recommends** that the report of the Council on Public Relations be filed. It commends Dr. Slobodien and his Council for a difficult job well done. For the information of the membership your Reference Committee wishes to state that the materials forming "The Thin Edge" (page) are available for group use.

Adopted

3. Resolutions:

a. Amendment of Medicaid Legislation — Resolution #7 (page Tr 96)

With the consent of the Passaic County Medical Society, your Reference Committee **recommends** amendments to Resolution #7 as follows: (a) delete line #8 and the word "but" on line #9; and (b) change the "Resolveds" to read:

RESOLVED, that The Medical Society of New Jersey declare its belief that quality medical care cannot be obtained by legislation which requires a dual standard of care.

RESOLVED, that The Medical Society of New Jersey shall actively work for changes in the Title XIX legislation and directives so as to allow a physician to be reimbursed for the additional costs of items consumed by or issued to the patient.

The Committee **recommends** that Resolution #7 be adopted as amended.

Adopted as amended by the Reference Committee

b. Exemption from Licensure — Resolution #8 (page Tr 96)

Unlicensed Physicians in Community Hospitals — Resolution #13 (page Tr 100)

The Reference Committee voted unanimously that Resolutions #8 and #13 be rejected.

Adopted

It was the Committee's feeling that to lower licensure standards was not in the best interest of patient care. The Committee **recommended**, however, that the State Board of Medical Examiners review licensure requirements, giving particular attention to foreign medical graduates who are professionally competent but have not yet passed their qualifying examinations for licensure.

Adopted

c. Federal Catastrophic Health Insurance — Resolution #9 (page Tr 97)

The Committee **recommends** approval of Resolution #9 with the following modification acceptable to its authors:

On line #15, insert the word "Federal" after "well-planned" so that the line should now read, "Whereas, well-planned Federal catastrophic insurance coverage would."

Adopted

The Committee also **recommends** that the "Resolved" portion be amended to read as follows:

RESOLVED, that The Medical Society of New Jersey request that the American Medical Association, through resolution at its June 1975 convention, assume the leadership in the study and promotion of catastrophic health insurance, and that in so doing the AMA draft, support, and actively seek implementation of an immediate plan to lessen the financial impact of catastrophic illness. (Italics indicate modified language.)

Adopted as amended by the Reference Committee

d. Relicensure of Physicians — Resolution #11
(page Tr 98)

The Committee **recommends** approval of Resolution #11, as amended with consent of its sponsors to read:

*Relicensure of Physicians
From the Hudson County Medical Society
(Reference Committee "E")*

Whereas, the private practice of medicine is progressively being adversely modified by legislation; and

Whereas, in most cases we have been advised not to be concerned because the particular bill was only "under consideration;" and

Whereas, our next knowledge is that this bill has been enacted and since it is now law we must abide by its provisions; and

Whereas, demands for repeal are met by the argument that we cannot prove how ill-conceived the law is until its adequacy has been proven in practice; and

Whereas, politicians promising improvements that could not and have not materialized have instead reduced the quality of health care and are actively creating the crisis they claim already exists; and

Whereas, the charge that we have failed in our obligation to protect the public from those among us who should not be allowed to practice gives no validity to the premise that politicians are better qualified to evaluate our profession; and

Whereas, there are adequate laws, rules, and regulations to rid the profession of its small number of incompetents; and

Whereas, the relicensure concept would place the physician's right to continue practicing medicine at the whim of an examining authority — without recourse; and

Whereas, MSNJ is already on record as requiring continuing medical education for continued membership; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively oppose any legislation or bureaucratic regulation that would require relicensure examination of physicians.

Adapted as amended by the Reference Committee

e. Professional Liability:

Legislation Regarding Malpractice Insurance — Resolution #10 (page Tr 98)

Statute of Limitations — Resolution #12 (page Tr 99)

Malpractice Law Revision — Resolution #24 (page Tr 106)

Malpractice Legislation — Resolution #33 (page Tr 111)

The Committee considered Resolutions #10, #12, #24, and #33 collectively. The great concern of the membership over professional liability is clearly evident and encompassed in the above-noted resolutions. It was noted that a similar concern and discussion ensued in Reference Committee "C." Basically there were multiple physician concerns: (a) the present jury system of awards; (b) statute of limitations; (c) *res ipsa loquitur*; (d) financial limitations on judgments; (e) lawyer contingency fees; (f) duplication of indemnification; (g) definition of "malpractice," and so on. The Reference Committee clearly cannot resolve all these items nor did any of the above resolutions. The Committee there **recommends** that these matters of professional liability be referred to a joint committee of the Council on Legislation and the Committee on Medical Defense and Insurance or a special ad hoc committee to be appointed by the President or the Board of Trustees.

Adopted

Reference Committee "F"

Daniel E. Boyle, M.D., Chairman

Reference Committee "F" met on Sunday, June 1, 1975, with all members present: Doctors William M. Chase, Michael J. Doyle, Carl A. Restivo, Robert A. Weinstein, Joseph W. Bit-sack (alternate), and the chairman. Approximately 30 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

a. Certificate of Need (page Tr 20)

The Committee **recommends** that the report be filed.

Adopted

b. Draft Planning Guide for Hospital Long Range Plans (page Tr 21)

The Committee **recommends** that the report be filed.

Adopted

c. Federal Catastrophic Health Insurance (page Tr 21)

The Committee **recommends** that the report be filed.

Adopted

d. National Health Planning and Resources Development Act of 1974 (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

2 Medical Services (page Tr 60) and supplemental (page Tr 61)

The Committee **recommends** that the reports be filed.

Adopted

The Committee further **recommends** that the Council on Medical Services schedule more frequent meetings because of the importance of the material within the purview of the Council that went unreported.

Adopted

3. Occupational Health, Workmen's Compensation, and Rehabilitation (page Tr 61)

The Committee **recommends** that the report be filed; although it was felt that it was incomplete, with a supplemental report inferred but not as yet reported.

Adopted

4. Mental Health (page Tr 62)

The Committee **recommends** that the report be filed; although the Committee felt that there should be more emphasis placed on this subject with relation to correctional institutions, including maximum security areas.

Adopted

5. Alcoholism (page Tr 63)

The Committee felt that physicians should be urged to become more involved in assisting in the total treatment of this disorder.

The Committee **recommends** that the report be filed.

Adopted

6. Drug Abuse (page Tr 63)

The Committee **recommends** that the report be filed.

Adopted

7. Emotional Disorders of Childhood and Adolescence (page Tr 64)

The Committee suggested review of the examination form and urged that physicians replace paramedics presently performing examinations.

The Committee **recommends** that the report be filed.

Adopted

8. Mental Retardation (page Tr 65)

The Committee **recommends** that the report be filed, and enthusiastically supports the endorsement of added financing to the Department of Institutions and Agencies to enable it to operate at peak efficiency.

Adopted

9. Neurological and Related Disorders (page Tr 65)

The Committee **recommends** that the report be filed.

Adopted

10. Resolutions:

a. HEW Ruling Concerning Medicare and Medicaid Admissions — Resolution #14 (page Tr 101)

The Committee **recommends** that Resolution #14 be adopted.

Adopted

b. New Jersey Self-Contained Area for P.L. 93-641, National Health Planning and Resources Development Act of 1974 — Resolution #15 (page Tr 101)

The Committee **recommends** that Resolution #15 be amended by changing the words "Camden County" in the first resolved to "The Medical Society of New Jersey."

Adopted

The Committee **recommends** that Resolution

#15 be adopted as amended.

Adopted as amended by the Reference Committee

c. Reimbursement to Physicians for Performing Utilization Review Functions — Resolution #16 (page Tr 102)

The Committee **recommends** that Resolution #16 be adopted.

Adopted

d. Updating Medicare Fees — Resolution #17 (page Tr 103)

The Committee **recommends** that Resolution #17 be adopted.

Not adopted

Amended by the House by addition to the resolved to read:

RESOLVED, that The Medical Society of New Jersey institute a study, and make recommendations to the Department of Health, Education, and Welfare for changes in Medicare legislation to permit fee allowance changes in a more expeditious and timely fashion, and that the carrier ask the appropriate Federal agency to inform the public of such changes.

Adopted as amended by the House

e. Hospital Application Forms for Present and New Staff Members — Resolution #28 (page Tr 108)

The Committee **recommends** that the following "Whereas" be added to Resolution #28:

Whereas, such applications constitute a direct invasion of the physician's privacy; now therefore be it

Adopted

The Committee **recommends** that Resolution #28 be adopted as amended.

Adopted as amended by the Reference Committee

f. National Health Resources Planning and Development Act of 1974 — Resolution #29 (page Tr 109)

The Committee **recommends** that Resolution #29 be adopted.

Adopted

g. **Payment by Blue Shield for Medical Consultation in Consultant's Office** — Resolution #30 (page Tr 110)

The Committee **recommends** that Resolution #30 be rejected.

Adopted

The Committee further **recommends** that the Council on Medical Services meet with representatives of Blue Cross-Blue Shield in an attempt to resolve this dilemma.

Adopted

h. **Utilization Review Position** — Resolution #31 (page Tr 110)

The Committee **recommends** that Resolution #31 be adopted.

Adopted

i. **Federal Regulations Mandating Hospital Utilization or Peer Review Procedures** — Resolution #32 (page Tr 111)

The Committee **recommends** that Resolution #32 be adopted.

Adopted

Reference Committee "G"

Frank M. Galioto, M.D., Chairman

Reference Committee "G" met on Saturday, May 31, 1975, with all members present: Doctors Arthur A. Goldfarb, Charles S. Krueger, Roger C. Laauwe, Watson E. Neiman, Ralph J. Fioretti (alternate), and the chairman. Approximately 25 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

Ad Hoc Committee to Formulate Guidelines for the Uniform Procurement of Blood (page Tr 122)

The Committee **recommends** that the report be filed.

Adopted

2. Public Health (page Tr 66)

The Committee **recommends** that the report be filed.

Adopted

3. Cancer Control (page Tr 66)

The Committee **recommends** that the report be filed.

Adopted

4. Child Health (page Tr 66)

The Committee **recommends** that the report be filed.

Adopted

5. Chronically Ill and Aging (page Tr 67)

The Committee **recommends** that the report be filed.

Adopted

6. Conservation of Vision, Hearing, and Speech (page Tr 68)

The Committee **recommends** that the report be filed.

Adopted

7. Environmental Health (page Tr 68)

The Committee recommends that the report be filed.

Adopted

8. Maternal and Infant Welfare (page Tr 69)

The Committee recommends that the report be filed.

Adopted

9. Resolutions:

a. Rubella Vaccination — Resolution #18 (page Tr 103)

The Committee felt that this Resolution would have no bearing at this time because the State has just passed a law requiring rubella vaccination.

The Committee recommends that Resolution #18 be rejected.

Adopted

b. Smoking — Resolution #19 (page Tr 103)

The Committee recommends that Resolution #19 be adopted.

Adopted

c. Non-Smoking in Enclosed Public Places — Resolution #25 (page Tr 107)

The Committee recommends that Resolution #25 be adopted with the following addition: On line #12, after the words "and all other" the

word "enclosed" be inserted so that it would read "and all other enclosed public gathering places . . ."

Adopted as amended by the Reference Committee

d. School Child Bus Safety — Resolution #26 (page Tr 107)

The Committee recommends that the "Resolved" portion of this Resolution be amended to read as follows:

"RESOLVED, that The Medical Society of New Jersey go on record as urging in the strongest possible terms immediate and forceful action by Governor Brendan T. Byrne to correct these inadequacies and to implement at once Resolution #17, dated May 20, 1969, in these child-related safety matters."

Adopted

The Committee recommends that Resolution #26 be adopted as amended.

Adopted as amended by the Reference Committee

e. Teenage Alcohol Education — Resolution #27 (page Tr 108)

The Committee recommends that on line 26, after the words "in our ranks" the words "and local school boards" be inserted.

Adopted

The Committee recommends that Resolution #27 be adopted as amended.

Adopted as amended by the Reference Committee

Reference Committee "H"

Donald P. Burt, M.D., Chairman

Reference Committee "H" met on Sunday, June 1, 1975, with all members present: Doctors Aldo G. Baldi, Harry W. Fullerton, Jr., A. Gerard

Peters, Edward H. Weiser, Frank R. Schell (alternate), and the chairman. Approximately 9 delegates and members were present to discuss

the various items under consideration.

1. Board of Trustees

a. Reference Committee Members (page Tr 23)

The Committee **recommends** that the report be filed.

Adopted

b. Members of the Press Attending Sessions of the House of Delegates (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

c. Annual Reports (page Tr 22) Annual Reports — Resolution #20 (page Tr 104)

The Reference Committee discussed these items together.

By way of explanation, it was brought out that reports would still be published in *The Journal*, and all would be available, if needed. Therefore, this involves mainly the distribution of reports.

Regarding Resolution #20, the Committee **recommends** that line 11 be amended to read: "*savings in printing and preparation and distribution costs;*".

Adopted

The Committee **recommends** that Resolution #20 be adopted as amended.

Not Adopted

The Committee **recommends** that the portion of the annual report of the Board of Trustees dealing with annual reports be filed.

Adopted

2. Annual Meeting (page Tr 28)

Objections were raised regarding the meeting room facilities at Cherry Hill Convention Center as being inadequate. These objections, and ultimate locations for the 1976 Annual Meeting

will be duly considered by the Committee on Annual Meeting.

The Committee **recommends** approval of the recommendation included in the annual report.

Adopted

The Committee **recommends** that the report be filed.

Adopted

3. Scientific Exhibits (page Tr 28)

The Committee **recommends** that the report be filed.

Adopted

4. Scientific Program (page Tr 29)

The Committee **recommends** that the report be filed.

Adopted

5. Honorary Membership (page Tr 31)

The Committee **recommends** that the report be filed.

Adopted

6. Woman's Auxiliary Advisory (page Tr 51)

The members present wished to congratulate formally the members of the Woman's Auxiliary for their increased activities.

The Committee **recommends** that the report be filed.

Adopted

7. Nominations for Emeritus Membership (page Tr 91) and supplemental (page Tr 91)

The Committee **recommends** that the report be filed.

Adopted

Report of the Nominating Committee and Election — June 1, 1975

Matthew E. Boylan, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	John S. Madara, M.D., Salem
1st Vice-President	1 year	Frank R. Begen, M.D., Bergen
2nd Vice-President	1 year	Charles S. Krueger, M.D., Burlington
Secretary	1 year	Arthur Bernstein, M.D., Essex
Treasurer	1 year	Rudolph C. Gering, M.D., Mercer
Trustees		
1st District	1 year	Augustus L. Baker, Jr., M.D., Morris
1st District	3 years	Edward G. Bourns, M.D., Union
1st District	3 years	William Greifinger, M.D., Essex
2nd District	3 years	John J. Crosby, Jr., M.D., Hudson
2nd District	3 years	Richard E. Lang, M.D., Passaic
3rd District	3 years	Frank Campo, M.D., Mercer
3rd District	3 years	Howard D. Slobodien, M.D., Middlesex
4th District	3 years	I. Edward Ornaf, M.D., Camden
Judicial Councilors		
1st District	3 years	Merton L. Griswold, Jr., M.D., Union
4th District	3 years	Frederick W. Durham, M.D., Camden
AMA Delegates		
	1 year	George L. Benz, M.D., Essex
	2 years	Louis F. Albright, M.D., Monmouth
	2 years	Joseph P. Donnelly, M.D., Hudson
AMA Alternate Delegates		
	1 year	Henry J. Mineur, M.D., Union
	1½ years	Myles C. Morrison, Jr., M.D., Morris
	2 years	Frederick W. Durham, M.D., Camden
	2 years	Alfred A. Alessi, M.D., Bergen
	2 years	William J. D'Elia, M.D., Monmouth
Delegates and Alternate Delegates to Other States		
Connecticut		
Delegate	1 year	Edward G. Bourns, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
New York		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	Josiah C. McCracken, Jr., M.D., Atlantic
Administrative Councils		
Legislation		
5th District	3 years	John S. Madara, M.D., Salem
6th Member	3 years	Winton H. Johnson, M.D., Bergen
Medical Services:		
5th District	3 years	Armando F. Goracci, M.D., Gloucester
6th Member	3 years	Edward P. Healey, M.D., Passaic
Mental Health:		
3rd District	3 years	Robert S. Garber, M.D., Mercer
6th Member	3 years	Evelyn P. Ivey, M.D., Monmouth
Public Health:		
5th District	3 years	Robert G. Salasin, M.D., Cape May
6th Member	3 years	Francis E. Rieman, M.D., Hudson
Public Relations:		
2nd District	3 years	Frank R. Begen, M.D., Bergen
5th District	3 years	Gastone A. Milano, M.D., Atlantic
Standing Committees		
Annual Meeting	3 years	Arthur C. Dietrick, M.D., Burlington
Finance and Budget	3 years	Louis G. McAfocs, Jr., M.D., Camden
Medical Defense and Insurance		
Insurance	3 years	Paul J. Kreutz, M.D., Union
Medical Education	3 years	Edward H. Weiser, M.D., Sussex
Publication	3 years	John F. Marshall, M.D., Mercer
Woman's Auxiliary Advisory ..	3 years	William J. Roe, M.D., Bergen

Accepted by the House

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- ☐ \$50 SUSTAINING

- ☐ \$100 ORGANIZATIONAL
- ☐ \$250 PILLAR
- ☐ \$500 SPONSOR
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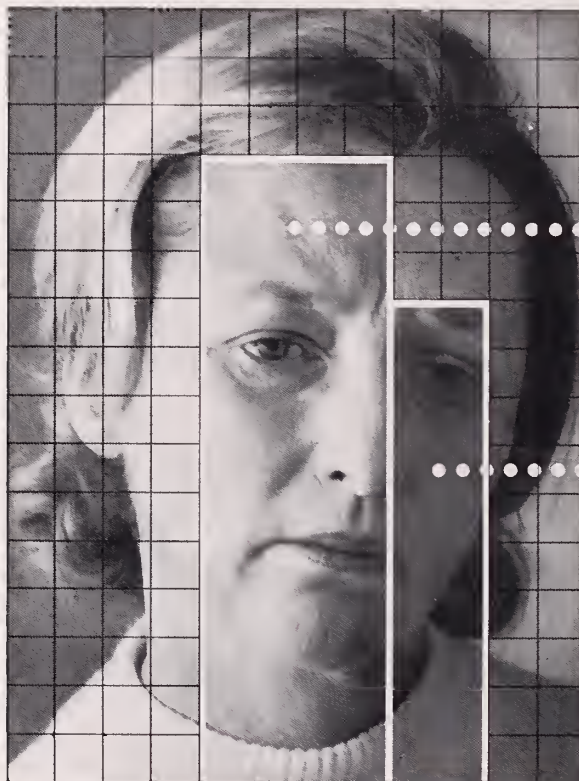
ZIP _____

ATTENDANCE

Official Attendance Report

County	Delegates	Members	Total
Atlantic	8	30	38
Bergen	41	65	106
Burlington	11	46	57
Camden	24	140	164
Cape May	2	3	5
Cumberland	5	10	15
Essex	71	156	227
Gloucester	5	20	25
Hudson	24	29	53
Hunterdon	2	2	4
Mercer	25	60	85
Middlesex	21	39	60
Monmouth	23	47	70
Morris	19	34	53
Ocean	9	29	38
Passaic	32	60	92
Salem	3	7	10
Somerset	4	16	20
Sussex	3	3	6
Union	33	56	89
Warren	3	3	6
Fellows and Officers	23	—	23
	391	855	1,246
Physician Guests			87
Physician Exhibitors			30
TOTAL PHYSICIAN REGISTRATION			1,363
Auxiliary			367
Visitors			441
Exhibitors			271
TOTAL REGISTRATION			2,442
REGISTRATION OF HOUSE OF DELEGATES			
Registration:			
Total Possible — Officers and Fellows			28
Total Possible — County Delegates			393
Total 1975 House of Delegates			421
Total Officers and Fellows Registered			23
Total County Delegates Registered			368
Total Registered			391
Attendance at House Sessions			
1st Session, 5/31/75			345
2nd Session, 6/1/75			361
3rd Session, 6/2/75 Part I			358
6/3/75 Part II			315
Average for All Sessions			345

Both often



Predominant
psychoneurotic
anxiety

Associated
depressive
symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuation (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Use with caution in individuals with known addiction-prone individuals under care.

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, though primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Golden Merit Awards

President's Remarks at 1975 Conference

We are gathered here today, at the 209th Annual Meeting of The Medical Society of New Jersey, to pay homage to a dedicated group of physicians — the recipients of the 1975 Golden Merit Award citation, which is given to those of our peers who have practiced medicine for fifty years. As President of The Medical Society of New Jersey, it gives me great pleasure to be a part of the tribute to this illustrious group and to extend to these physicians our gratitude for a magnificent performance.

By your deeds you have honored your profession. Your path has not been an easy one, but the loyal and dependable services you have performed have brought medicine into a new era. There is no doubt medicine is being challenged today in ways you never envisioned, even in your wildest dreams. However, the groundwork you have established with your proficiency and desire to widen your medical horizons has given us a rock to build upon. We accept the gifts that your years of service have provided to humanity, and strive, to the best of our ability, to improve on the art of medicine.

The practice of medicine today was nurtured by you wonderful servants of Hippocrates. Whatever distinction we have is owed to you and physicians like you for your tireless effort on behalf of your fellow humans.

In honor of the legacy of excellence you have bestowed upon the medical profession, and as a small token of our admiration and esteem, we are presenting you with the Golden Merit Award of The Medical Society of New Jersey, in recognition of your meritorious service.

We would be remiss if we did not acknowledge the sacrifices made by your families in sharing the demanding life of a physician so that you could administer to the needs of your patients.

We wish you and your families the best of everything and many more years to enjoy the fruits of your labor. Our sincere gratitude for a job well done.

RECIPIENTS 1975

Atlantic County

Martin Hollenbach Gold, M.D., Margate City

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Victor August Blenkle, M.D., Teaneck
Albert Williams Cloud, M.D., Englewood
Werner Gould, M.D., Hackensack
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Louis A. Hitzemann, M.D., Maywood
Emanuel B. Kaplan, M.D., Teaneck
Herbert Neuwalder, Sr., M.D., Closter
Lorenz Charles Nicol, M.D., Albuquerque, N.M.
Francis Patton Twinem, M.D., Hackensack
Orlin Vincent Wry, Sr., M.D., East Rutherford

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Cape May County

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Charles Anthony Minnefor, M.D., South Orange
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Emanuel Bailyn, M.D., Palm Beach, Fla.
Sylvester Aloysius Choffy, M.D., Maywood
Ben B. Markowitz, M.D., Sarasota, Fla.
Henry Oshrin, M.D., West New York

*Sunday, June 1, 1975, Cherry Hill

Joseph A. Visconti, M.D., Spring Lake Heights
Thomas J. White, M.D., Jersey City

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Albert James Fessler, M.D., Trenton
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Sidney Brooks, M.D., Hollywood, Fla.
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Ernest I. Kyle, M.D., Lakewood
James E. Stuart, M.D., Plainfield
Ronald J. Walsh, M.D., Coral Gables, Fla.

Quotes from the Governor's Conference on Delivery of Health Care*

The Honorable Brendan T. Byrne:

"I think it is important that we have a *veterans' hospital* in South Jersey."

"... We have a shortage of doctors in South Jersey... the logical way to keep physicians is to have a *medical school* (without walls) in South Jersey... the first two years of training would be taken up in Piscataway and the second two years here in South Jersey."

"I think that we have got to continue to evaluate the *certificate of need* program in terms of being realistic, in terms of having a valid standard to apply to a certificate of need program and in terms of not getting into every minor application for a certificate of need."

"The field of *hospital rate setting* is one which I think the State has to get into realistically."

"I have a group... evaluating what the State's proper and legal role ought to be in the field of *abortion*. I suspect that, from the legal standpoint, the State's role in abortion regulations, especially in the first trimester, will be pretty severely limited, at least by the Courts."

"What I want to do in the field of *malpractice* today is to assure you of the complete cooperation of the State of New Jersey in a logical approach to the malpractice problem. I am willing to consider, if this represents a rational approach, the involvement of the State of New Jersey as a direct insurer in the field of malpractice insurance. We will not stand by, as a State, and let inequities appear and be preserved and be tolerated... without taking strong and courageous action against those inequities."

"... A proposal by the Department of Higher Education with respect to legislation authorizing practice by a *physician's assistant* in the State is another area where I think you (the Medical Society) ought to get involved. I ought to have input from you and your association."

The Governor has asked for your opinion, so why not give it to him on each of these issues? Let the Governor and the Legislature of this State know how you feel about matters of public importance.

*The 1st Annual Governor's Conference on "Unresolved Questions Affecting Delivery of Health Care," Saturday, May 31, 1975, Cherry Hill, New Jersey

Why and How Political Action

James S. Todd, M.D.

Let me promptly assure you I am not here as an apologist for JEMPAC, AMPAC, or indeed, even the AMA. I am here because I want to be, because I am proud of organized medicine and its accomplishments, yet not naive enough to think it has all the answers. I am here because I believe in American medicine and its organizations, yet am not deluded into thinking our full potential has been reached. And, I am here because I believe as never before American medicine is threatened both from within as from without, and there is no clear unified game plan for the future. This worries me and it should worry you!

In recent years there has been a remarkable expansion of federal activity in the health care field, an expansion measured not only in funding, but more importantly, into areas of determination and control. None of us can remain indifferent to this trend, and regardless of our sentiments, we can hardly be unconcerned by it.

The health care system in the United States is indeed changing, and like it or not, the federal government is the principle instrument of that change.

In the last twenty-five years the federal government has moved from a minor to a major position in the health care system in this country. Now close to one-third of all health care expenditures come from federal funds. They supply seventy percent of all expenditures for research, sixty percent of the cost of physician education, and forty percent of all payments for health services and supplies. The fact is that health is one of the most heavily subsidized industries in this country — a fact that health professionals may like to ignore, but one that the politicians see as a potent political force. Add to this, the massiveness of the industry which employs 4.5 million people, receives ten percent of the entire federal budget and uses seven percent of the gross national product, and it's not difficult to see why the federal government is interested in

health care, and why that interest will steadily increase.

Of more immediate concern, however, is the fact that this huge federal involvement in the American health care system never has been, and is not now being guided by people who have any perception of the consequences of their decisions and actions. Yet, let's not take too much satisfaction in that realization because we must also recognize that there is no real leadership of the American health care system either — only an array of special interests, each determined to promote its own cause at the expense of others. When we as a profession show no unity, how can we expect the government or Congress to act wisely. It was very difficult, for example, for the American Medical Association to appear before Congress arguing against the PSRO Law when in the same room were nine state societies arguing in favor of the PSRO Law. Without congressional ability to make rational decisions, and without consistent leadership from the health care system, we can expect to see fundamentally important decisions made in total ignorance of their impact and consequences.

There is an old Chinese curse which says, "May you live in interesting times." Even a quick look at our current political scene confirms that curse. Harry Schwartz, a real friend of medicine, talks about a national attitude of frustration, an absence of direction, and an ill-defined but generalized anger which divides, deforms, and attacks those institutions until now held quite sacred.

The Ninety-Fourth Congress is an excellent example. Medically speaking, it is disoriented with preterminal metastasizing ambitions. It is a Congress in transition, a Congress without leadership. Indeed, all the hallowed leaders are falling either into tidal basins or before the recently elected young and hungry liberals, few of whom have ever been gainfully employed and even fewer of whom understand the legislative process. So far, this Congress has been one of indecision, confusion, and inaction, but there are

*Presented before the JEMPAC Breakfast, June 2, 1975, 209th Annual Meeting, MSNJ, Cherry Hill.

clearly certain areas and priorities it intends to pursue, and already some relatively good predictions can be made in these areas as they pertain to medicine.

The biggest issue is and will continue to be the economy. All subsequent issues really depend upon the solution of the current economic situation. The Democratic Steering Committee worked out a program and didn't have sense enough to consult with the entire Democratic caucus; the result was a disaster. President Ford remains indecisive, so it seems unlikely that any concerted integrated program will be produced. The economy will continue to be handled from crisis to crisis. Of course, totally dependent upon the economic solution is the whole question of national health insurance. Representative Ullman says a bill will be passed, Senator Kennedy remains consistently socialized, and President Ford is trying to ignore the whole thing. And while Congress sees this as a potent political tool, they also fear the consequences of increased inflation, if not downright failure of a sweeping national health insurance program. There are those, however, now willing to recognize that the nation must move toward a rational system of health care financing which distributes the cost over the largest possible portion of the population and provides practical incentive for cost control and quality assurance. It is virtually certain that we will see no national health insurance in 1975 and it is doubtful in 1976, although it almost certainly will be a campaign issue, it is most probable that some form of national health insurance will be passed in 1977.

There is no room for complacency. We still have a great deal of selling to do, most of all to the public, who really don't seem too interested, and to those politicians who are still not philosophically committed.

We also have to think about medical liability. There has been a great deal of talk at this convention, and in the country-at-large, about the problem of professional liability. Senator Kennedy immediately introduced a bill in the Congress, but it seems impossible for him to give us a clean bill. He tied legal relief to professional relicensure every six years! Others in the

Congress are talking about reinsurance through HEW, federal umbrella insurance for claims over \$200,000, and a national medical malpractice insurance program. The best estimate and advice is that the federal government should stay out of this area and let the states pass appropriate legislation.

At the moment, the best legislation would seem to be (1) ceilings on liability awards, (2) determination of injury, (3) modification of contingency fee, and (4) a change in the statutes of limitations. To this I would add a fifth: recognition that three hundred and some odd thousand physicians can no longer support the liability of 210 million Americans and still give first class medical care. It is totally, actuarially unsound and will not be successful under any equitable system.

There are, of course, many other areas of interest to the medical profession, but the ultimate issue is — can this Congress forego internal politics enough to deal creatively and effectively with the problems that come before it? All evidence to date indicates that they cannot and this, as never before, opens the door for external influence, lobbying, pressure politics, call it whatever you want. If we miss this opportunity to fill the gap and tell our government what we believe, what we want, and how close we are to open revolt, then we will invite destruction by default.

All of this sounds easy, but you know, we as physicians have a particular trait which is both an asset and a liability at the same time. That is our individuality. From the moment we enter medical school, indeed even before, or we would probably never get to medical school, we are taught to be self-sufficient individuals, to make our own decisions, to accept the consequences of those decisions and, perhaps most dangerous, to expect everyone else to accept our evaluations and act according to our directions.

There is, then, a peculiar tendency for physicians to reject leadership. Think about it, it's true! Get four doctors together and ask them the time of day and you will get four different answers; worse yet, all four are pre-prepared to defend their answers. More than any other group, doc-

tors by their very nature are reluctant to delegate authority and the result is a splintering of the profession into ever smaller groups, each trying to fulfill parochial needs and each trying to maintain its own concept of individuality. Look at the congress of county medical societies, now only their journal remains viable. The council of medical staffs remains oblivious to anything but their own concepts. Specialty groups become ever more restrictive and exclusive in their memberships. And finally, unions, which when fully operative, represent that ultimate loss of individuality.

How easy it is to forget that we are all basically physicians with basically common interests and goals. When Senator Long says he doesn't care about 350,000 physicians, and when the Department of Health, Education, and Welfare can roll our fees back arbitrarily to 1971, and when the doctors of New York can physically fight with one another in the House of Delegates, and when less than half of the physicians belong to the one national parent organization, then you had better believe we have one gigantic problem. We have a problem not only with the legislators and the public but also with ourselves, and it is to ourselves that we must look for the answers.

There is a world out there with people in it and we need to talk with these people. They want to know our thoughts for no one else will tell them for us. They want to hear our ideas for some tell them we have none. Most importantly, they want to know that we recognize their needs; they really don't think we do. For too long the medical profession has remained silent on socioeconomic issues until now we are called reactionaries whenever we speak out on matters we know are contrary to good medical care. We need to demonstrate that physicians stand ready to participate in any program calculated to improve our nation's health, but that we do not stand ready to be swallowed in a convulsive revolution of health care which sacrifices quality and individuality for expediency.

We need make no apologies for the present health care system regardless of what its detractors may say. The quality and quantity of medical services in the United States are now at an all time high and, in the aggregate, compare favorably with the situation in any other nation

in the world. All the statistics show our citizens believe this also. In a recent poll, eighty percent of citizens were satisfied with the quality and availability of health care. Nine out of ten people already have some form of health care insurance. Health care ranks fifteen on a list of sixteen national priorities as determined by the public, and physicians still rank tops in public esteem and trust. These are not the attitudes of a demanding citizenry in revolt against a floundering profession. It seems more than coincidental that in the past twenty years, the medical profession has been subjected to increasing amounts of criticism primarily from two sources — the federal government and organized labor. Ironically, neither the government nor labor has shown much concern for efficiency in its own operations. One can have little confidence in the government seeing the penny postcard costing eight cents and then realizing the main boost of this cost is unrestrained escalation in manpower costs.

Obviously medicine has its imperfections, but we need not hide them, and perhaps need not even be ashamed of them. But we must also recognize that there is no single simple solution to these imperfections. There are too many factors affecting health care for that and most of them are beyond medical control. Accidents, over-indulgence, pollution, and poverty are all areas for which the medical profession is being held responsible, but for which the solutions are clearly not medical.

Good modern health care extended to all the people in this inflationary period will be expensive and will continue to cost more. It is perfidy for the politicians to say otherwise. And if the government really means what it seems to be saying, then quality or availability of health care should not depend upon costs nor should considerations of cost determine the rate of progress of the type of care to be given. The failure of Congress, despite heavy political pressure, to bring out any major medical legislation indicates there is no easy solution, even politically, to the problem of health care and its financing. It seems increasingly clear that since politics is the fine art of compromise, no one group is going to be able to control future medical care and its financing. Success in this regard will go to those best skilled in negotiating and "politicking".

At last, we get to JEMPAC and AMPAC, which after all was the purpose of this meeting in the first place. Before you can really influence something, you need people who will listen to you, and even better, might share some of your philosophies. This is the primary function of the political action movement — to provide sympathetic legislators who will listen to the wisdom and counsel of our medical lobbyists.

Although the political action movement was created by the American Medical Association House of Delegates in 1961 and receives financial aid, AMPAC and JEMPAC are distinct and separate from the AMA and MSNJ. The so-called "soft dollar contributions" are the source of all the PAC's educational, training, and promotional projects. Candidate support or political funds must and do come solely from PAC membership. The PACs do not lobby nor do they take stands on legislative issues. This is the function of the Medical Society.

This is an important distinction, for one need not feel the subjugation of his political beliefs when joining the PAC. PAC's sole function is to assure the election of intelligent, capable, and reasonable legislators with whom the doctors may then communicate. And JEMPAC is bipartisan. The concept of medical political action is to encourage physicians and their wives to become good political party members.

In 1974, AMPAC membership increased by twelve percent. Here in New Jersey, we have 220 members which is already more than in all of 1974. Eighty-two percent of the members of the House of Delegates of the American Medical Association are members of a PAC group. In twenty-one states all delegates to the AMA are PAC members. There are those who become sustaining members of the PAC movement, which means that they have enough confidence to contribute above and beyond the basic dues structure. Eighty-three percent of those in the AMA House of Delegates, who belong to a political action movement, are sustaining members. Unfortunately, only seven percent of those in New Jersey are sustaining members. In 1974, JEMPAC received \$17,000 for candidate

support for the national organization, far more than it contributed.

Obviously, the measure of any organization is its record. The last election was one of the most unusual in our history and one of the most difficult to predict, yet the political action program was enviable. In 1974, AMPAC spent over one million dollars in candidate support. In the Senate AMPAC participated in twenty-two races; they won six and lost one Democratic race; they won nine and lost seven Republican elections, for a sixty-three percent batting average. In the House, AMPAC participated in 248 contests and ended up with a seventy-four percent batting average of those elected who were supported by AMPAC. This isn't bad when you figure that COPE of the AFL-CIO spent four times as much with no better results.

So my message for you is that we can and must develop the dedication, leadership, unity, and influence required to determine our own professional destinies. No one has all the answers to any of our nation's health care problems, but American medicine has a legitimate primary role to play if it will but assume it. We need to admit we don't run a perfect system, but are trying to improve it and need help, not control. It's also time we got off the defensive and told the government and the people of all the other ways in which medicine serves — a heritage of honor so long hidden in needless professionalism. We must impress upon the people that we still believe in, and will insist upon, the principles of private enterprise and freedom of choice. Most of all, we should tell the government that we want them to join us and the public in a new concept of responsibility and restraint that ultimately will achieve good health care for all at a price all can afford.

We can no longer afford the luxury of opposition without viable alternatives to solve clearly existing problems. No longer can we criticize the government without actively trying to change it. We need not be precipitous in action, but we do need to maintain credibility. We need not compromise with principle, but we do need to be flexible. Most of all, we need to be seen to be heard, and to be positive.

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The safety of ethaverine hydrachlaride during pregnancy or lactation has nat been established; therefore it should nat be used in pregnant women or in women of childbearing age unless, in the judgment of the physician, its use is deemed essential ta the welfare of the patient.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period.

PRECAUTIONS: Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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Trustees' Minutes

May 30 and June 3, 1975

Two regular meetings of the Board of Trustees were held during the 1975 Annual Meeting in Cherry Hill. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

May 30, 1975

DHEW Rates for Medicare Patients . . .

Received as informative a report from the Vice-President of Prudential Insurance Company for Governmental Affairs, William White, concerning recent actions of DHEW whereby that Department plans to roll back the index to the 1971 rates for Medicare patients. It was agreed to discuss the matter with the President of the AMA who was in attendance at the Annual Meeting.

Medical Defense and Insurance . . . Approved the following recommendations from the Committee on Medical Defense and Insurance and directed that they be referred to Reference Committee "C."

1. That the following rate increase applicable to all classes of practice be approved:

Increase in Limits Factors	—	24.3%
Additional Increase	—	23.7%
Total		48 %

2. That the Joseph A. Britton Agency be authorized to place the coverage for the umbrella policies with the carrier that offers the best advantages to MSNJ members.

3. That MSNJ urge the College of Medicine and Dentistry of New Jersey to present mandatory courses on professional liability in the medical school curriculum.

4. That the AMA urge such curriculum (mandatory courses on professional liability) inclusion in the nation's medical schools.

5. That MSNJ aggressively initiate an educational program directed toward the Governor, the legislature, and the public to secure support for remedial legislation.

June 3, 1975

Introduction of New Member . . . Welcomed Frank Campo, M.D., 3rd District, a newly elected member of the Board of Trustees.

. . . Noted that Charles S. Krueger, M.D., was elected to the office of Second Vice-President;

that Arthur Bernstein, M.D., was elected to the office of Secretary, and that Rudolph C. Gering, M.D., was elected to the office of Treasurer.

Reorganization of the Board . . . Elected James S. Todd, M.D., Chairman of the Board for 1975-1976; elected Edward G. Bourns, M.D., Secretary of the Board for 1975-1976; agreed to continue meeting regularly at 10 a.m. on the third Sunday of each month in the Executive Offices (subject to cancellation if the agenda proves insufficient); elected Richard E. Lang, M.D., as Board of Trustees member on the Committee on Finance and Budget for a three-year term (1975-1978).

Standing Committee on Physicians' Relief Fund . . . Re-elected Frank Y. Watson, M.D., to membership on the Standing Committee on Physicians' Relief Fund, to succeed himself, for a three-year term (1975-1978).

Repeal Earnings Test for Social Security (Resolution #3):

RESOLVED, that The Medical Society of New Jersey use its resources and facilities actively to support the passage of United States Senate Bill 410; and be it further

RESOLVED, that The Medical Society of New Jersey urge the American Medical Association through introduction of a resolution at their June 1975 Convention, actively to support the passage of United States Senate Bill No. 410.

. . . Directed that Resolution #3 be referred to the New Jersey delegation to the AMA for drafting an appropriate resolution to be submitted to the AMA House of Delegates in June 1975.

Smoking (Resolution #19):

RESOLVED, that smoking of any material shall be prohibited in all deliberative meetings of all official bodies connected with The Medical Society of New Jersey.

. . . Directed that notice of the adoption of Resolution #19 be sent to each of the component medical societies and to the chairmen of all MSNJ councils and committees. (No smoking signs will be placed in MSNJ headquarters and ash trays will be removed from meeting rooms.)

Non-Smoking in Enclosed Public Places (Resolution #25):

RESOLVED, that The Medical Society of New Jersey urge the New Jersey Legislature to pass a law whereby the rights

of non-smokers will be protected in all covered places where the public gathers; and be it further

RESOLVED, that such places as theaters, indoor arenas, elevators, street cars, buses, planes, passenger aircraft, and all other enclosed public gathering places should be restricted as to smoking areas; and be it further

RESOLVED, that designated restricted areas be provided for the smoking public in such enclosed public places.

. . . Referred Resolution #25 to the Council on Legislation for implementation.

School Child Bus Safety (Resolution #26):

RESOLVED, that The Medical Society of New Jersey go on record as urging in the strongest possible terms immediate and forceful action by Governor Brendan T. Byrne to correct these inadequacies and to implement at once Resolution #17, dated May 20, 1969, in these child-related safety matters.

. . . Directed that an official communication be sent to Governor Byrne setting forth the inadequacies of the current safety system in school buses, urging that Resolution #17 of the 1969 House of Delegates be implemented by the State.

Teenage Alcohol Education (Resolution #27):

RESOLVED, that our organization, at the county, state, and national level, encourage, supervise, coordinate, and support programs, in cooperation with parents and the schools, which will arrest or alleviate this growing problem; and be it further

RESOLVED, that the school physicians in our ranks and local school boards undertake a survey of the extent of the problem in their respective schools and intensify alcoholism education programs through lectures, films, and student and parent group discussions.

. . . Directed that Resolution #27 be referred to the Council on Public Health.

Amendment of Medicaid Legislation (Resolution #7):

RESOLVED, that The Medical Society of New Jersey declare its belief that quality medical care cannot be obtained by legislation which requires a dual standard of care; and be it further

RESOLVED, that The Medical Society of New Jersey shall actively work for changes in the Title XIX legislation and directives so as to allow a physician to be reimbursed for the additional costs of items consumed by or issued to the patient.

. . . Directed that Resolution #7 be referred to the Council on Medical Services.

Federal Catastrophic Health Insurance (Resolution #9):

RESOLVED, that The Medical Society of New Jersey request that the American Medical Association, through resolution at its June 1975 convention, assume the leadership in the study and promotion of catastrophic health insurance, and that in so doing the AMA draft, support, and actively seek implementation of an immediate plan to lessen the financial impact of catastrophic illness.

. . . Directed that Resolution #9 be referred to the New Jersey Delegates to the AMA for drafting of an appropriate resolution to be submitted to the AMA House of Delegates in June 1975.

Relicensure of Physicians (Resolution #11):

RESOLVED, that The Medical Society of New Jersey actively oppose any legislation or bureaucratic regulation that would require relicensure examination of physicians.

. . . Directed that Resolution #11 be referred to the Council on Legislation for its information.

Professional Liability:

Legislation Regarding Malpractice Insurance (Resolution #10)

Statutes of Limitations (Resolution #12)

Malpractice Law Revision (Resolution #24)

Malpractice Legislation (Resolution #33)

. . . Directed that Resolutions #10, #12, #24, and #33, together with pertinent excerpts from the report of Reference Committee "E," be referred to the Council on Legislation and the Standing Committee on Medical Defense and Insurance for joint consideration and subsequent report to the Board of Trustees.

Professional Liability Insurance Crisis (Resolution introduced from the floor of the House)

RESOLVED, that The Medical Society of New Jersey urge the Governor and the Legislature of New Jersey to enact reasonable and effective remedial legislation; and be it further

RESOLVED, that The Medical Society of New Jersey urge the Courts of New Jersey to adopt a rational approach in deciding medical liability cases and in effecting rules of court; and be it further

RESOLVED, that if the above measures are not effected within 6 months, that the physicians of New Jersey be urged to withhold all but emergency medical services, and that a special session of the House of Delegates be convened to reassess this position and the implementation of these recommendations; and be it further

RESOLVED, that the President of The Medical Society of New Jersey and the Board of Trustees formulate a plan utilizing the Council on Public Relations and the Council on Medical Services to inform the public of our position and the physician-members of our anticipated action.

... Directed that the following actions be taken regarding the resolution on Professional Liability Insurance Crisis:

(a) That it be referred to the Councils on Public Relations and Medical Services for joint action;

(b) That a copy of the proposed legislation on reform of medical malpractice laws drafted by MSNJ and approved by this Board in April 1975, be sent to the Governor with a covering letter urging his support;

(c) That a copy of the proposed legislation on reform of medical malpractice laws be sent to each legislator in New Jersey;

(d) That, as soon as possible, a meeting of the Conference Committee on Inter-Relations with the Judiciary and Bar be scheduled. W. Lewis Bambrick, Esquire, Assistant Director, Administrative Office of the Courts, will be requested to arrange this meeting and to invite the Chief Justice, or in the Chief Justice's absence, another member of the Court;

(e) That copies of this Resolution and the drafted legislation be sent to each Supreme Court judge;

(f) That if after five months definite, positive action has not been taken by the legislature, a special session of the House of Delegates be convened;

(g) That by way of general mailings, the membership be contacted and urged to inform their patients of the professional liability situation and request their patients to contact their legislators; and

(h) That component medical societies be requested to stress the importance of physician-patient communication at all county meetings.

(i) That copies of the drafted legislation be sent to each newly-elected trustee and officer.

HEW Ruling Concerning Medicare and Medicaid Admissions (Resolution #14):

RESOLVED, that The Medical Society of New Jersey urge its membership not to participate in the implementation of this regulation through any utilization committee or otherwise.

... Voted to table consideration of Resolution #14 until the July meeting when the outcome of litigation between the AMA and the Department of HEW will be known, and requested the Executive Director to present his opinion as to the legality of implementation of this resolution.

New Jersey Self-Contained Area for P.L. 93-641: National Health Planning and Resources Development Act of 1974 (Resolution #15):

RESOLVED, that The Medical Society of New Jersey endorse the request for the waiver from the original law by the Governor and urge the Commissioner of Health, the federal legislators, and the state legislators to support this waiver; and be it further

RESOLVED, that this resolution be presented to the House of Delegates of The Medical Society of New Jersey for its concurrence and that it instruct its American Medical Association Delegates to introduce a resolution in its House urging the integrity of state boundaries under P.L. 93-641.

... Directed that Resolution #15 be referred to the New Jersey delegation to the AMA for drafting of an appropriate resolution to the AMA House of Delegates in June 1975.

Reimbursement to Physicians for Performing Utilization Review Functions (Resolution #16):

RESOLVED, that The Medical Society of New Jersey go on record as actively supporting the principle that physicians should be reimbursed for their time devoted to utilization review; and be it further

RESOLVED, that this action of The Medical Society of New Jersey be made known to all third parties which benefit from physician participation in utilization review.

... Directed that Resolution #16 be referred to the Council on Medical Services and to the New Jersey Hospital Association through MSNJ's liaison representative, Dr. Madara.

Updating Medicare Fees (Resolution #17):

RESOLVED, that The Medical Society of New Jersey institute a study, and make recommendations to the Department of Health, Education, and Welfare for changes in Medicare legislation to permit fee allowance changes in a more expeditious and timely fashion; and that the carrier ask the appropriate federal agency to inform the public of such changes.

... Directed that Resolution #17 be referred to the Council on Medical Services.

Hospital Application Forms for Present and New Staff Members (Resolution #28):

RESOLVED, that The Medical Society of New Jersey record itself as opposing the use and implementation of such applications; and be it further

RESOLVED, that The Medical Society of New Jersey instruct its delegates to the American Medical Association to present this resolution in proper form to the AMA House of Delegates in June, 1975, for its consideration and action.

. . . Voted to postpone action on the first "Resolved" and directed that a resolution be drafted for submission to the AMA House of Delegates in June 1975.

National Health Resources Planning and Development Act of 1974 (Resolution #29):

RESOLVED, that the House of Delegates of The Medical Society of New Jersey urge the AMA to do all within its power to assure that health service areas under this law remain within the geographic boundaries of the respective states unless the affected states have voluntarily waived jurisdiction.

. . . Noted that action previously taken on Resolution #15 encompassed the intent of Resolution #29.

Utilization Review Position (Resolution #31):

RESOLVED, that The Medical Society of New Jersey vigorously support the AMA's lawsuit against the Utilization Review Regulations proposed by HEW to be implemented July 1.

. . . Directed that the AMA be notified of MSNJ's position of active support in this litigation.

Federal Regulations Mandating Hospital Utilization or Peer Review Procedures (Resolution #32):

RESOLVED, that federal regulations mandating hospital utilization or peer review procedures be applied uniformly to all hospitals, including city, county, state, public health, and VA hospitals; and be it further

RESOLVED, that this resolution be introduced at the AMA convention for adoption and action.

. . . Directed that Resolution #32 be referred to the New Jersey Delegation to the AMA for drafting of an appropriate resolution to the AMA House of Delegates in June 1975.

Countersigning of House Officers' Hospital Orders and Temporary Limited Licensure (Board of Trustees' Annual Report):

. . . Directed that the following excerpt from the report of Reference Committee "D" be referred to the Council on Medical Services:

Reference Committee "D" recommended that the Board of Trustees of The Medical Society of New Jersey continue its efforts to bring about a ruling by the State Board of Medical Examiners providing a temporary certification to carry on all the functions of the physicians in the hospital setting to house staff in AMA-approved residencies for the first eighteen months of their training, after which they would be expected to become regularly licensed.

1976 Annual Meeting . . . Received a report from the Chairman of the Committee on Annual Meeting, Arthur Bernstein, M.D., which revealed that facilities to accommodate meetings, exhibits, and social events will be available at the Cherry Hill Hyatt House for MSNJ's 1976 annual meeting; representatives from the Annual Meeting Committee and MSNJ staff will investigate this possible meeting site further.

Nominating Procedure . . . Directed that the Special Committee on Long Range Planning and Development review the guidelines for the conduct of the Nominating Committee and the actual nominating procedure and submit recommendations for consideration at the September meeting of the Board.

Improved Public Relations and Legislative Programs . . . Directed that the following five-point program be reviewed by a committee consisting of the Chairman of the Council on Legislation, the Chairman of the Council on Public Relations, and the Executive Director, and that a report be submitted to the Board within three months with recommendations for implementation:

(a) That, in order to permit greater efforts toward passage or defeat of major bills in the legislature, the Council on Legislation consider taking action only on those bills which it feels merit active support or opposition and those bills specifically brought to its attention by component societies or specialty societies;

(b) That the Council on Legislation devote more time to the drafting and introduction of progressive legislation;

(c) That the current keyman system be revised.

(d) That the Council on Legislation and the Board of Trustees develop a system by which legislators and the members of the administrative branch of government can be successfully urged to consider MSNJ's position regarding legislation and regulation pertaining to the practice of medicine; and

(e) That, in conjunction, the Council on Legislation and the Council on Public Relations launch a campaign to insure total coverage of major medical society activities.

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Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Important Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, periph-

eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.

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JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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SEPTEMBER 1975

VOL. 72, NO. 9

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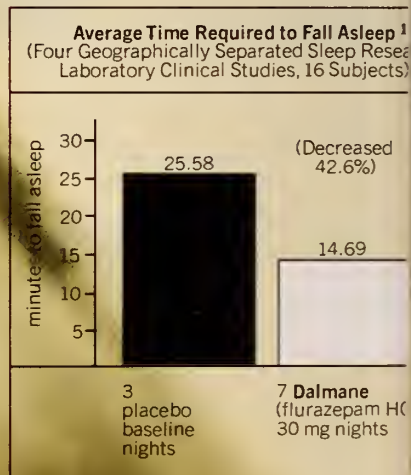
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Precautions: In elderly and debilitated, initial
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complaints. There have also been rare
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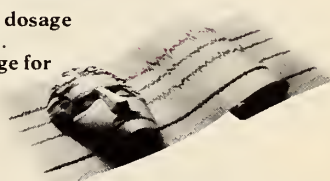
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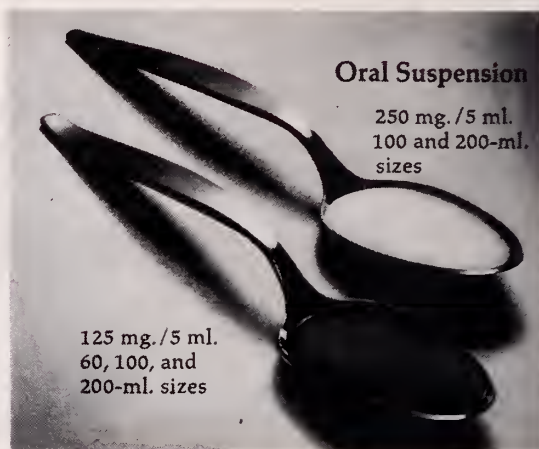
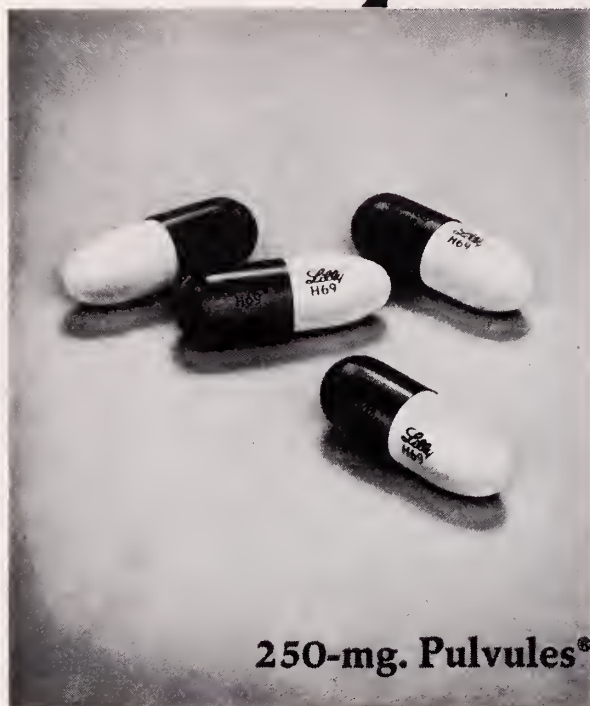
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EDITORIALS

In Unity There Is Strength

Physicians find themselves beset on all sides — working in an atmosphere of distinct patient hostility, hedged in by all sorts of governmental regulations, required to fill out forms without limit, and accused in the public press and privately of being singlehandedly responsible for all the evils and ills of our society. It is not surprising then that initial physician reaction to the “malpractice crisis” is the threat of boycott if remedial measures are not immediately forthcoming.

Being knowledgeable about human behavior and possessed of better than average intellect, we physicians ought to bring these attributes to bear on this problem and abandon an emotional approach. The latter only produces further emotional responses such as the unconstitutional threat to suspend physician licenses.

Working with the state and local medical societies, it should be possible to outline the present impact of the professional liability insurance problem on physicians and on patients, as well as to develop reliable future projections. Combining this information with the insurance carrier's knowledge, it should be possible to outline constructive legislation. The potential impact of the developing PSRO's should be brought into consideration, and liaison between these organizations and local medical societies ensured for their mutual benefit. Sharing relevant statistics and other information will strengthen each.

We must all recognize that the professional liability insurance problem is shared by *all* physicians. In the past, the physician ranks have been split apart too often when specialty societies pursued their own narrow needs and officials and delegates to the state medical society failed to recognize that a threat to the rights of one small specialty group constitutes a threat to every physician.

A reasonable course of action is required in this “malpractice crisis.” The plan for such action must be logical, unimpassioned, and based on solid factual data. It must be implemented by an organization that visibly commands the political support of at least 90 percent of the physicians of New Jersey in order to have maximal impact on the state legislators. The only physician organization that has the manpower resources and the contacts with the legislative and governmental offices in Trenton and which has the role of spokesman for the majority of physicians is The Medical Society of New Jersey.

This is not an issue on which narrow self-interest may be indulged; furthermore, profit will not be gained by specialty societies pursuing their own course. This dilemma must be met by all physicians who have decided on a common course and are vigorously pursuing it through the one organization. If there are disagreements as to the best course to follow, these should be resolved within the Society prior to presentation of a plan outside of it.

The Medical Society leadership recognizes that a very serious problem exists and that the threat to even one physician represents a threat to all. The membership at large must appreciate this and support its elected officials.

In the words of John Hancock: “We had all better hang together or we'll all hang separately.”

William A. Dwyer, Jr., M.D.

Threshold of Intolerance

We are all fully aware of the concept of “threshold,” the point at which a stimulus just produces a response, or the concentration of a substance in the plasma above which the material is excreted by the kidneys. Thus, the “pain threshold” and “renal threshold for glucose” appear in our daily conversations and writing. Did you ever think of the “threshold of intolerance” in a similar way?

If we consider "tolerance" to be the "disposition to be patient and fair toward those with different opinions," we may expand the postulate to include feelings of forbearance, endurance, indulgence, and sympathy. Although it is not an all-or-none principle, intolerance (a better word would be "hypotolerance") is the usual antithesis. The threshold level of pain seems to be genetic or constitutional to a large extent, but it is modifiable by external factors, just as the renal threshold for glucose may be lowered by tubular injury or raised by arteriolar nephrosclerosis. To carry this thought further, we might consider one's personal threshold level of intolerance to be genetic or constitutional, but also capable of modulation by outside influences.

Some of these factors are simply quantitative while others are qualitative, temporal, physical, or emotional. Fatigue, for example, will clearly lower one's threshold of intolerance. It is most difficult to return the endless phone calls from an over-anxious family at the end of a hectic 16-hour work-day. Did you ever mutter "damnedlonghairedfreak" at a youngster whose compact car darted in front of you as you were rushing to the hospital emergency room to see a patient who has just been "coded" and is undergoing cardiopulmonary resuscitation?

It is much easier to be gracious and understanding to the tenth patient with flu-like symptoms at 1 p.m. than to the twentieth who rings your bedroom phone at 1 a.m. Threshold levels of intolerance for paperwork vary with the number of complexities of the forms, the responsiveness of the government agency or carrier, payment considerations, and a host of additional irritants which are frustratingly beyond control. As your vacation approaches and emergency piles upon emergency, — patients you have not heard from in two years demand to be seen immediately, and the chairman of the medical records committee declares your hospital admissions' privileges suspended until completion of 12 delinquent charts, — your threshold of intolerance may tumble to a new low!

So what can be done to maintain one's intolerance threshold at a reasonable level, or even to raise it a bit? First, one should be aware of the

general level of his tolerance and should understand the specific and general factors which tend to make him less tolerant. These obviously include avoidance of fatigue, maintenance of control over one's professional activities, and provision for adequate relaxation and vacation time with family and friends. One must be organized and systematic to a reasonable degree. Impulsive answers and reactions must be controlled. Participation in community activities should be strictly regulated within the limits of one's interests and available time, and not allowed to become burdensome. There are obviously many other considerations, but the most important one is to learn to say "NO!" A.K.

Do You Have a Question or Problem Case?

Your editorial staff is attempting to serve the membership of MSNJ in a number of ways through various departments in *The Journal*. Do you regularly read the Therapeutic Drug Information pages? This monthly feature provides individual responses to queries — even by telephone, if requested. (See page 761, this issue)

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The Journal will be pleased to receive from its readers questions on problem cases for referral to the appropriate expert for an answer or opinion. If we don't have an expert on our list to respond to your query, we will find one.

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Iatrogenic ureteral trauma is not uncommon during abdominal surgery, especially gynecologic surgery for cancer. Early recognition and prompt reconstructive surgery is highly desirable. Ureteroneocystostomy is the treatment of choice in lower ureteral trauma. Boari flap procedure should be used when lower ureteral trauma is more extensive. Transureteroureterostomy and ureteroileocystostomy are useful alternatives in properly selected patients.

Diagnosis and Management of Iatrogenic Ureteral Injuries

**Parvez Mahmood, M.D. and
Marvin P. Jassie, M.D., and
Mircea Golimbu, M.D./Lakewood***

The ureter is injured during a variety of surgical procedures. The most common cause of ureteral injury is gynecologic surgery, particularly radical hysterectomy for carcinoma of cervix. Incidence of ureteral injury following gynecologic surgery for benign disease varies from 0.05 to 2.42 percent^{1,2}. On the other hand, the incidence following radical pelvic surgery is much higher; varying from 10 percent in Werthiem's original series to 30 percent in other series.^{3,4} The ureteral injury may occasionally follow sigmoid resection, resection of abdominal aortic aneurysm and intraureteral stone manipulation. Injuries to the ureter have been known to occur in almost any operation in the general vicinity of the ureter.⁵

Recognition of Ureteral Injury

Prompt recognition and treatment of an iatrogenic ureteral injury is of paramount importance. The time of recognition of an injury exerts profound influence on management and is probably the single most important factor controlling the results of any form of therapy.

Intraoperative Recognition — Treatment will depend on the cause of injury, which may include one of the following:

- (1) Ligation
- (2) Complete or partial division
- (3) Puncture
- (4) Excision or avulsion of a segment
- (5) Crushing
- (6) Transfixion
- (7) Angulation
- (8) Indirect compression

Intraoperative recognition of a ureteral injury has considerable advantages since repair can be

accomplished in a clean surgical field which is free of fibrosis and edema. Depending on the etiology and the site and extent of injury, appropriate therapy can be instituted.

(b) Postoperative Recognition — Early recognition of ureteral injury in the immediate postoperative period is possible if the patient develops symptoms and signs, such as flank pain or fever, anuria (in bilateral injuries only), or a urinary fistula. Early diagnosis is also possible if the surgeon has a high index of suspicion because of undue technical difficulties during surgery and obtains a postoperative excretory pyelogram.

Delayed diagnosis of a ureteral injury is usually incidental. An excretory urography performed for an unrelated symptom may show a non-functioning or hydronephrotic kidney. Sometimes, the ureteral injury is recognized at the time of a second abdominal operation.

Diagnosis of the Site and Extent of Ureteral Injury

Excretory pyelography postoperatively may show one of the following:

- (1) Non-visualization of one or both kidneys,
- (2) Delayed visualization of one or both kidneys,
- (3) Pyelocaliectesis or ureterectesis (unilateral or bilateral), or
- (4) Extravasation of contrast material at the site of ureteral injury

If excretory pyelography fails to give required information to make a diagnosis one may proceed to retrograde studies.

*Dr. Mahmood is Urologist at Paul Kimball Hospital in Lakewood; Dr. Jassie is Chief of that department. This article is based upon material collected while Dr. Mahmood was a resident in urology at NYU — Bellevue Medical Center.

Retrograde passage of a ureteral catheter has diagnostic, as well as, therapeutic importance. If the catheter easily bypasses the site of extravasation or obstruction, it usually means that the ureter is not completely transected and the catheter should be left in place for drainage. With a complete ureteral transection x-rays will reveal the catheter curled in the retroperitoneal space. Failure to bypass the site of injury signifies complete or incomplete obstruction.

Occlusive tip pyelogram shows the site of obstruction or extravasation and delineates the total length of the obstructed ureteral segment.

Management of Ureteral Injury

The spectrum of treatment of ureteral injury is wide and varies from watchful waiting to major surgical procedures involving bowel.

The following factors will have to be considered before instituting definitive therapy:

- (1) interval between occurrence of injury and diagnosis,
- (2) status of ipsilateral and contralateral kidney,
- (3) site of injury (distance from bladder),
- (4) extent of ureteral damage, and
- (5) age and general condition of patient

Conservative Management — One can afford to observe the patient without instituting any therapy if the ureteral injury does not lead to complete obstruction of the kidney, the patient is afebrile, and does not have flank pain. It is essential that the patient must be hospitalized during the observation period for extremely close supervision. The renal status must be monitored by frequent excretory pyelograms.

If the patient develops flank pain or fever, cystoscopy should be performed and an attempt made to pass a ureteral catheter. If the catheter passes, it should be left indwelling for ten to fourteen days and then removed.

Operative Management — Depending on the factors previously mentioned, one of the following procedures is selected:

- (1) Ureteroureterostomy
- (2) Ureteroneocystostomy

- (3) Boari flap
- (4) Transureteroureterostomy
- (5) Ureteroileocystostomy
- (6) Downward displacement of affected kidney and ureter
- (7) Bladder hitch operation
- (8) Autotransplantation of affected kidney in iliac fossa
- (9) Ureterosigmoidostomy

Clinical Material

Between September 1963 and November 1972, fifteen patients required definitive reconstructive surgery following ureteral injury. (Table 1) There were eleven females and four males. The mean age was 49.1 years. Injury was unilateral in twelve cases (right-8, left-4), and bilateral in three cases. (Table 2)

Ten cases of ureteral trauma followed gynecologic surgery; six had been operated upon for cancer and four for benign disease. Two cases followed sigmoid resection. Transurethral resection of a bladder tumor situated on the ureteral orifice resulted in ureteral trauma in one case. Pelvic radiation for a possible metastatic focus in lumbar vertebrae (the primary cancer was rectal carcinoma) resulted in ureteral fibrosis in another. Resection of an annular pancreas resulted in ureteral damage in one patient with a duplicated collecting system.

Recognition of Injury

Ureteral trauma was recognized in only two cases during initial surgery. Case #10 underwent a transurethral resection of a bladder tumor situated on the ureteral orifice. The ureteral injury was recognized during the procedure and a ureteroneocystostomy was subsequently performed. Case #14 had a sigmoid carcinoma extending into the left ureter. Sigmoid resection with segmental resection of the ureter and a primary ureteroureterostomy were performed. Iatrogenic trauma was recognized fairly early in eleven cases (within six weeks of initial surgery). All of these patients had become symptomatic during the early postoperative period and this prompted the urological evaluation and diagnosis.

Ureteral injury was recognized quite late in three patients. A nonvisualizing kidney was found in one patient one year following radiation therapy. The second instance of delayed diagnosis involved a patient who had sigmoid

resection for carcinoma of the colon. The diagnosis was made on an incidental intravenous pyelogram two years following surgery. The third case of delayed recognition occurred in a patient with a duplicated collecting system who had resection of an annular pancreas. Right sided hydronephrosis, involving both systems, was recognized about nine months later when excretory pyelogram was done because of persistent epigastric pain and an upper abdominal mass.

Operative Procedures

A total of seventeen operations were performed on fifteen patients. Two patients had two procedures each; case #10 had an unsuccessful ureteroneocystostomy followed by a Boari flap; case #8 had a nephrectomy following an unsuccessful Boari flap procedure. Ureteroneocystostomy and Boari flap procedure which were the most commonly used reconstructive procedures were used in an equal number of patients (five each). Transureteroureterostomy was performed on two occasions. Extensive bilateral ureteral necrosis necessitated bilateral ureteroileocystostomy in one patient. Nephrectomy was performed on two occasions as definitive surgery; one patient had had a two-year interval between ureteral trauma and diagnosis, and the second patient had multiple peritoneal abscesses following leakage from a Boari flap. Primary ureteroureterostomy was performed on one occasion. Case #15 had sustained damage to both ureters of a duplicated collecting system. A proximal pyeloureterostomy and a distal ureteroureterostomy were performed to bypass both strictures. (Table 2)

Results

Good results (no hydroureteronephrosis; asymptomatic) were obtained in eleven patients. One patient had an acceptable result (minimal to moderate hydroureteronephrosis; asymptomatic) following bilateral ureteroneocystostomy. Minimal ureteral stricture persisted at the right ureterovesical junction. However, the patient was asymptomatic and only had an occasional urinary tract infection which was easily controlled with urinary antiseptics.

Two patients died twenty-four hours postopera-

Table 1

		Type of Ureteral Injury	
Patient	AgeSex		
1	65 F	Bilateral ureterovaginal fistulae secondary to radical hysterectomy for carcinoma of cervix. (extensive lower ureteral damage)	
2	65 F	Bilateral ureterovaginal fistulae secondary to radical hysterectomy for carcinoma of cervix. (mid-ureteral damage)	
3	52 F	Bilateral lower ureteral damage secondary to total abdominal hysterectomy and salpingo-oophorectomy for benign uterine mass.	
4	32 F	Right distal ureteral injury following emergency hysterectomy for placenta accreta.	
5	43 F	Right distal ureteral trauma following radical hysterectomy for carcinoma of cervix.	
6	47 F	Left lower ureteral injury following vaginal hysterectomy and anterior repair for stress incontinence.	
7	22 F	Right lower ureteral injury following radical hysterectomy for carcinoma of cervix.	
8	45 F	Right lower ureteral injury following radical hysterectomy for carcinoma of cervix.	
9	46 M	3000 rads to pelvis for lumbosacral metastases leading to left ureteral stricture.	
10	50 M	Right ureteral trauma following resection of bladder tumor situated on right ureteral orifice.	
11	76 M	Left distal ureteral damage following sigmoid resection for carcinoma.	
12	32 F	Right lower ureteral injury during hysterectomy done for fibroids.	
13	72 F	Right ureteral injury during radical abdominal hysterectomy done for carcinoma of uterus.	
14	71 M	Left ureteral injury during resection of sigmoid colon for carcinoma.	
15	29 F	Double collecting system on right. Injury to both ureters during resection of an annular pancreas.	

tively, probably from an acute myocardial infarction; autopsy was not obtained. Case #10 had a ureteroneocystostomy following transurethral resection of a bladder tumor situated on the uretral orifice. A persistent ureterocutaneous fistula necessitated re-

Table 2
Operative Procedures

<i>Patient</i>	<i>Initial Procedure</i>	<i>Recognition of Injury</i>	<i>Reconstructive Operative Procedure</i>	<i>Preliminary Nephrostomy</i>
1	Radical hysterectomy	12 days po*	Bilateral Boari flap	None
2	Radical hysterectomy	14 days po	Bilateral ureteroileo-cystostomy	Bilateral nephrostomy
3	Total abdominal hysterectomy	13 days po	Bilateral ureteroneo-cystostomy	Right nephrostomy
4	Total abdominal hysterectomy	15 days po	Right ureteroneo-cystostomy	Right nephrostomy
5	Radical hysterectomy	18 days po	Right Boari flap	None
6	Vaginal hysterectomy	10 days po	Left ureteroneo-cystostomy	None
7	Radical hysterectomy	10 days po	Right Boari flap	None
8	Radical hysterectomy	11 days po	Right Boari flap	None
9	Pelvic radiation	9 months post radiation	Transureterouretero-ureterostomy	None
10	Endoscopic resection of bladder tumor	intraoperative	1) Ureteroneocystostomy 2) Transureterouretero-stomy	None
11	Sigmoid resection	2 years po	Left nephrectomy	None
12	Total abdominal hysterectomy	2 days po	Right ureteroneo-cystostomy	None
13	Radical hysterectomy	27 days po	Right Boari flap	None
14	Sigmoid resection	intraoperative	Primary uretero-ureterostomy	None
15	Resection of annular pancreas	10 months po	Pyeloureterostomy and ureterouretero-stomy (duplicated pyelocalyceal system)	None

*Postoperative

exploration and a right to left trans-ureteroureterostomy was performed. The patient leaked urine intraperitoneally, developed multiple abscesses and succumbed to sepsis. Case #8 had a right-sided Boari flap procedure. Persistent intra- and extraperitoneal urinary leakage prompted re-exploration and right nephrectomy. The patient eventually recovered. The latter two cases were considered technical failures. (Table 3)

Table 3
Operative Results

Good Result	11
Acceptable Result	1
Result Unknown*	1
Technical Failures	2
Total	15

*Patient expired; no autopsy was obtained

Case Reports

Case #1: A 65-year-old female underwent a radical hysterectomy in July 1970 for stage I carcinoma of the cervix. On the eighth postoperative day she developed low back pain and right costovertebral angle tenderness. An intravenous pyelogram done on the fourteenth postoperative day revealed grade I-II caliectesis bilaterally. The right ureter was not seen well but the left ureter was normal. There was no urinary extravasation. Physical examination at this time revealed a tender left lower abdominal mass which was interpreted as a possible hematoma. Low back pain and bilateral costovertebral tenderness persisted, but the patient remained afebrile; it was decided to manage the patient conservatively. She was placed on broad-spectrum antibiotics and was discharged from the hospital on the twenty-eighth postoperative day. Subsequent intravenous pyelograms as an outpatient showed progression of hydroureteronephrosis and bilateral lower abdominal masses displacing both ureters medially and the bladder inferiorly. The patient was readmitted to University Hospital in November 1970 for further management. An x-ray at this time revealed marked hydroureteronephrosis on the left with medial displacement of the left bladder wall. The right kidney failed to visualize. (Figure 1)



Figure 1 — Left hydroureteronephrosis with medial displacement of left bladder wall.

Bilateral retrograde pyelograms confirmed the hydro-ureteronephrosis and revealed medial deviation of the lower halves of both ureters, indicating the presence of bilateral pelvic masses. (Figure 2)



Figure 2 — Retrograde pyelogram showing hydro-ureteronephrosis and medial deviation of both ureters.



Figure 3 — Followup x-ray reveals good renal function and normal collecting systems.

In view of these findings, bilateral nephrostomies were performed. The patient did well postoperatively, but two weeks later underwent an exploratory laparotomy. Large lymph-filled cystic masses were encountered in the pelvis on either side of the bladder. The ureters were being obstructed by these lymphoceles and the areas of the ureters adjacent to the lymphoceles were extremely fibrotic. Both lymphoceles were totally excised and the ureters were transected and implanted in an ileal loop, one end of which was closed; the other end was anastomosed to the bladder. The patient did well and is totally asymptomatic three years following surgery. A follow-up x-ray revealed good renal function and normal collecting systems bilaterally. (Figure 3)

Case #2: A 71-year-old male developed alternating diarrhea and constipation with occasional black stools in October 1972. Studies revealed a carcinoma of the sigmoid colon. An exploratory laparotomy was performed and a lesion of the sigmoid colon, involving the left ureter, was found. The segment of the ureter was excised enbloc with the bowel and a primary ureteroureterostomy was performed. Postoperative intravenous pyelogram was completely normal. (Figure 4)

Case #3: A 32-year-old female delivered a full term, normal child in February 1970. Uncontrollable hemorrhage followed the second stage of labor. A diagnosis of placenta accreta was made and an emergency hysterectomy was performed. Three days postoperatively, the patient developed right flank pain and fever. An intravenous pyelogram revealed hydroureteronephrosis on the right side. In view of high fever and marked symptoms, a diverting nephrostomy was performed in April 1970. The patient did well postoperatively. Right flank pain and fever subsided completely. About three months later the patient was explored transabdominally and a marked fibrosis of the right distal ureter was found. The



Figure 4 — Postoperative study showing uretero-ureterostomy.

fibrosed portion of the ureter was excised and a ureteroneocystostomy was performed using modified Paquin technique. The patient did well postoperatively and is totally asymptomatic three years after surgery. An x-ray performed three years after surgery was completely normal. (Figure 5)

Discussion

Iatrogenic ureteral trauma is not an uncommon entity for which a urologist is consulted. As expected, most cases follow radical gynecologic surgery done for carcinoma of the cervix. However, four of our patients underwent gynecologic surgery for benign disease, suggesting that the index of suspicion for a ureteral injury should be kept high following any gynecologic procedure. Time of recognition of the ureteral injury is of utmost importance. Most of the patients who were diagnosed early eventually had good to excellent results. Delayed diagnosis following bowel surgery resulted in a nephrectomy which could have been prevented had the diagnosis been made earlier. Ureteroneocystostomy is the procedure of choice if the injury involves the lower third of the ureter. It is a relatively simple operation and has a very high success rate. Downward mobilization of the kidney and upward mobilization of bladder ("bladder hitch") can be successfully



Figure 5 — Three-year followup study showing ureteroneocystostomy.

and easily combined with ureteroneocystostomy, gaining extra length and avoiding tension at the suture line. Boari flap operation proved to be a very useful procedure in our hands when the lower ureteral damage was rather extensive and enough ureteral length could not be obtained for ureteroneocystostomy. The ureter was implanted in the Boari flap using modified Paquin technique and most cases were splinted for ten to fourteen days. Occasionally the damage to the ureter is so extensive that one has to use a bowel segment to bridge the defect. We performed a bilateral ureteroileocystostomy in one patient with excellent results. Although our experience in using a bowel segment for extensive iatrogenic ureteral injury is limited to one case, it is an extremely useful procedure in properly selected patients. Our experience with trans-ureteroureterostomy is rather limited, but it appears to be a promising procedure in properly chosen cases. On occasion a nephrectomy as a definitive procedure is required for a damaged kidney or for a poor-risk patient. One should be

very reluctant to remove a kidney unless obvious strong indications exist. In most cases some form of reconstructive surgery with good results is possible. If clinically indicated, a nephrostomy should be done as the initial procedure to relieve obstruction and reconstructive surgery scheduled at a later date.

Summary

Iatrogenic ureteral trauma is not uncommon during abdominal surgery, especially gynecologic surgery for cancer. The index of suspicion for a ureteral injury should be kept high following such surgery. Early recognition and prompt reconstructive surgery is highly desirable. Ureteroneocystostomy is the treatment of choice in lower ureteral trauma. Boari flap procedure should be used when lower ureteral trauma is more extensive. Tran-

sureteroureterostomy and ureterileocystostomy are useful alternatives in properly selected patients.

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River Avenue and Prospect Street

Gastroenterology — Stephen M. Levine, M.D.*

Matching the sigmoidoscopic or proctoscopic appearance with the disease:

Disease

1. Ulcerative colitis
2. Diverticulitis
3. Granulomatous colitis (Crohn's disease)
4. Amebiasis
5. Antibiotic induced enterocolitis, e.g., clindamycin

Proctoscopic Appearance

- a. Pseudomembrane formation and friability
- b. Friable mucosa
- c. Normal
- d. Discrete punched out ulcers
- e. Water flask ulcerations

1-b — In ulcerative colitis, the characteristic appearance of the mucosa is a friable lining that bleeds easily on contact. Histologically, an acute and chronic inflammatory process is seen in the lamina propria with crypt abscesses.

2-c — Since diverticulitis usually involves the proximal sigmoid colon and descending colon, and because the problem resides in the diverticulum itself, the observed mucosa of the rectum itself and distal sigmoid appear normal.

3-d — While there may be no sigmoidoscopic changes in Crohn's disease, or occasionally

friability of the mucosa may be seen, the distinguishing endoscopic feature of Crohn's disease is a punched-out ulcer similar to an aphthous ulcer of the mouth.

4-e — While acute amebiasis may look very much like acute ulcerative colitis, in occasional cases and in many cases of chronic amebiasis, a minute ulcer covered by a whitish exudate is seen. The ulcer burrows into the mucosa and then spreads out with the ulceration wider in the deeper layers of the mucosa than at the superficial layers of the mucosa.

5-a — Certain antibiotics, most notably recently clindamycin, have been associated with pseudomembranous enterocolitis that can mimic ulcerative colitis and have been responsible for a significant morbidity. This antibiotic should only be used when specifically indicated since there is a significant morbidity to the colitis.

*From "The Cooper Review" (May 1975) published by the Department of Medical Education, Cooper Medical Center, Camden, New Jersey, where Dr. Levine is Chief Attending Gastroenterologist.

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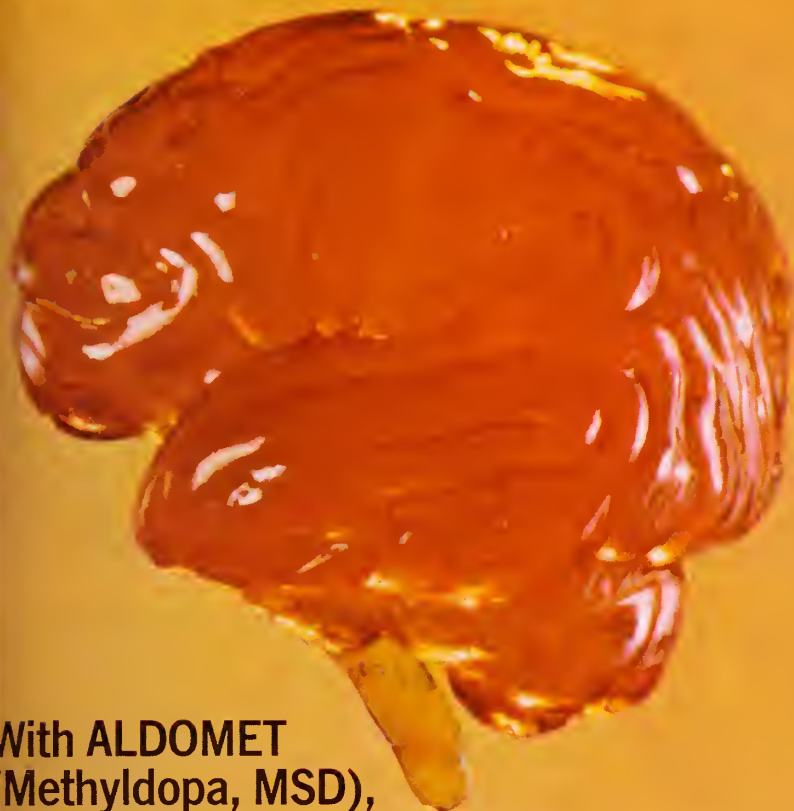


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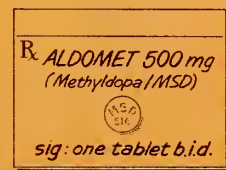
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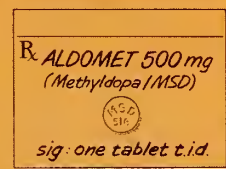
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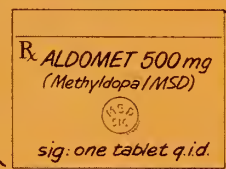
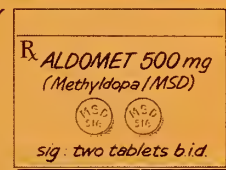
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With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reaction or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia, Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, skin rash.

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A concept of a team approach to treatment of advanced carcinoma of the head and neck is described. The principles include utilization of high-dose preoperative radiotherapy combined with radical surgery, preoperative oral care, and utilization of prosthetics for oral rehabilitation to improve the postoperative course. Three cases are reported, two in which this approach was utilized from the outset of patient evaluation as opposed to one case which was taken over by the team after initial therapy elsewhere.

Radical Approach to Advanced Carcinoma of the Head and Neck by Multi-Disciplined Team

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Squamous cell carcinoma of the head and neck, in its early stages, is a curable lesion. The treatment has usually consisted of either local surgical excision or radiotherapy. The preference in treatment has often depended on whether the radiotherapist or the surgeon was the initial evaluator of the disease, whether the geographic area had either a strong radiotherapy or a strong head and neck surgical service, or whichever was more in vogue at the particular time in history. In the past, either modality has provided excellent results for early very limited lesions. Unfortunately lack of early presenting symptoms or neglect on the part of the patient to seek advice for a particular complaint has resulted in a large number of head and neck carcinomas presenting at an advanced stage.

Even when present for a long period of time, the disease still may be confined to its original site, with only regional nodal involvement but without distant metastases. These large advanced regional carcinomas of the head and neck (Stages 3 and 4) present formidable problems to both the surgeon and radiotherapist. Because of the proximity of vital structures, extensive resection with safe margins has often been a difficult task. Even with extensive resec-

tions, the cure rate has been quite low and generally unacceptable. Rehabilitation of those patients who have had extensive resections and been cured of their disease has often been neglected.

Recognizing the need to improve the cure rate in these extensive carcinomas, the concept of radical radiation therapy followed by radical surgery has been advocated.¹ Resistance to this approach has occurred because of the fear of extensive tissue damage and increased morbidity and mortality resulting from radical courses of radiotherapy. Attempts at a compromise, utilizing low dosage preoperative radiotherapy, do not seem to be able to match the cure rates effected by the more radical approach.^{2, 3}

To lessen the morbidity we felt that initial evaluation by the radiotherapist and the surgeon, who jointly would plan and follow the patient through the course of therapy and decide upon the appropriate time for surgery, would significantly reduce the morbidity. This concept worked so well that it allowed us to become even more radical in our surgical approach. The more radical nature of the surgery, however, caused greater rehabilitative problems in the postoperative period. Recognizing the need to

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eradicate the disease and to improve the cure rate but also to return the patient to society as a useful individual, we had to modify our approach and preplan our management of the patient's inevitable postoperative problem. This naturally led to an expanded concept of the evaluating team to include a radiotherapist, head and neck surgeons, dentists, oral surgeons, and prosthodontists.

The following case presentations illustrate this concept.

Case One

A 54-year-old male had a history of pain in the right posterior region of the tongue intermittently over a year. Examination revealed a large tumor mass beginning on the right side of the tongue at about the circumvallate papillae and progressing downward crossing the mid-line to involve the entire base of the tongue on both the left and right sides. There was a two centimeter node in the right mid-cervical region (T3N1 Stage 3)[†] The lesion was biopsied and reported as infiltrating squamous cell carcinoma.

This patient was given a preoperative course of Cobalt-60 radiotherapy; the primary tumor and the entire neck to the level of clavicles were treated to 5000 rads in five weeks. The primary site was then exposed to another 1000 rads in one week. This was supplemented with oral hydroxyurea.^{††} Six weeks later a total glossectomy, laryngectomy and right radical neck dissection were performed. (Figure 1-a) He had an uneventful post-operative course. The patient required tube feedings for a prolonged period of time because of his inability to swallow secondary to loss of tongue. Eventually the tube was removed, and he was taught to insert a small feeding tube into the posterior pharyngeal area so that he could feed himself. With practice he is now able to swallow liquids and some soft foods even without a tongue; he no longer requires tube insertion. Because of the loss of the tongue, we questioned whether he could learn standard esophageal speech; it was tried and met with lit-



Figure 1-a — (Case One) Intraoral view. Absent tongue. Palate, floor of mouth visible with small posterior choana surrounding uvula.



Figure 1-b — (Case One) View of patient with minimal visible physical defect using electrolarynx for speech.

tle success. Our speech therapist, however, then turned to the electric larynx substitute. Initially the Western Electric #5 Electrolarynx[®] was tried, but this did not produce intelligible speech. However, using a Cooper-Rand Electrolarynx[®] he has made good progress and can produce intelligible speech. (Figure 1-b) Emotionally he has been rehabilitated and has returned to regular work as a house painter.

Case Two

A sixty-seven-year-old male presented with a history of a ten pound weight loss, a mouth odor, and a sensation of "something in the back of his throat." Symptoms had been increasing for six months.

Examination revealed a massive tumor which involved the entire right side of the soft palate and extended superiorly as a projecting mass up into

[†]Greater than 4 centimeters, ipsilateral node.

^{††}Hydrea[®] (Squibb)

the nasopharyngeal region, down the right side to involve the tonsil and right pharyngeal wall (Figure 2-a) to the mid-tonsil level inferiorly and crossing the mid-line of the palate to just the opposite side of the uvula. (T3 N1 Stage 3)† There was a two centimeter freely moveable node in the right mid-cervical area. The lesion was biopsied and proved to be squamous cell carcinoma. The patient was then presented to a planning conference.



Figure 2-a — (Case Two) Lesion involving tonsil and right half of palate

Initially his remaining upper teeth were removed and an impression was made of his palate. A course of external irradiation with Cobalt-60 equipment was prescribed; a dose of 4400 rads was delivered to the primary site and upper two-thirds of the neck through lateral opposed fields in 22 increments in five and one-half weeks. Because of severe radiation reaction, the patient had a split course with one week interruption in the middle. The dose level was not as high as we would have liked, but was stopped because of the extreme tissue reaction. Five weeks after com-

†Greater than 4 centimeters, ipsilateral node.

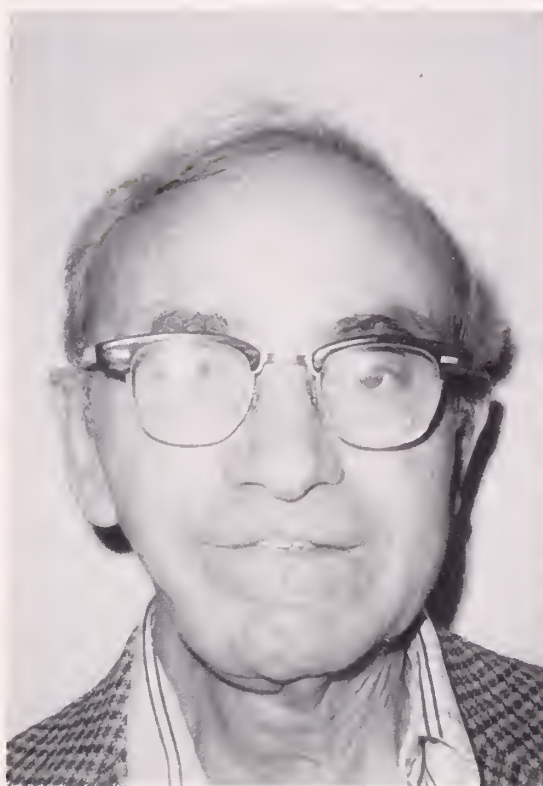


Figure 2-b — (Case Two) Patient with minimal cosmetic defect postoperatively

pletion of radiation therapy the patient underwent a right radical neck dissection, partial mandibulectomy, resection of the right tonsil, right pharyngeal wall, entire soft palate and a portion of the hard palate on the right. He healed well (Figures 2-b, 2-c) and was discharged on the tenth post-operative day; he had significant hypernasal speech and some degree of nasal regurgitation when swallowing. A temporary palate prosthesis, which was eventually revised



Figure 2-c — (Case Two) Post resection with palatal defect



Figure 2-d — (Case Two) Obdurator filling palatal defect

into a permanent obdurator after total healing occurred was made (Figure 2-d) This occludes the nasopharynx, prevents regurgitation on swallowing and effects normal speech. The patient, who is now in his second postoperative year has had no evidence of reoccurrence at the primary site and is functioning normally.

Case Three

A 59-year-old male initially presented with an ulceration in the floor of the mouth; biopsy revealed it to be squamous cell carcinoma. A full course of Cobalt-60 radiotherapy which consisted of 6400 rads was delivered to the floor of the mouth, submaxillary, and subdigastric nodal regions bilaterally through two parallel, opposed portals in 32 segments over a seven-week-period, with a two-week rest period after 4000 rads.

With the reappearance of the primary disease, the patient was referred to the Head and Neck Service and hospitalized. At that time there was a large ulceration with surrounding induration in the left anterior floor of the mouth; it involved the anterior surface of the mandible and the undersurface of the anterior portion of the tongue. Most of the lower teeth were present; a left submental node was apparent. (T3 N1 Stage 3)[†]

Since the initial course of radiotherapy was considered to be adequate, no additional radiation was planned. Surgery consisted of resection of the anterior floor of the mouth, anterior tongue, anterior mandible (from not quite angle to angle), left radical neck dissection and a right

supraomohyoid dissection, all in continuity. Because of the prior radiotherapy, no attempt was made to use a prosthesis or bone graft to replace the anterior mandible. (Figure 3-a) The wound was closed primarily with the residual tongue filling in the defect in the floor of the mouth defect. (Figure 3-b) This tongue has remained functional and allows for swallowing. The remaining edges of the mandible have been involved in an osteomyelitic process, which required removal of additional teeth and a filing down and removal of some of the projecting osteomyelitic mandible. There was a postoperative drooling problem which was successfully corrected by a tympanic neurectomy.⁴ The patient subsequently returned to his regular job as a supervisor at an automotive plant.

This patient differs from cases one and two in that he was not initially evaluated by the Head and Neck Service and referred to us only after the finding of residual disease following radiotherapy. Although he has been salvaged and functions well, there have been prolonged problems with oral rehabilitation because of lack of initial pretherapy, oral hygiene and removal of carious teeth. Case three represents an excellent example of the need for the team approach from the initial evaluation through the post-therapy follow up care.

Comment

The need for improvement of the health status and cure rate of the patient with carcinoma of the head and neck has provided the impetus for the formation of a multi-disciplined treatment group.

After initial evaluation of the patient by the radiotherapist and surgeon, a planned course of therapy should be instituted. During the course of therapy, the surgeon and radiotherapist see the patient together at frequent intervals to discuss his progression. At approximately six weeks after radiotherapy, definitive surgery is accomplished. Recently we have added chemotherapy with oral hydroxyurea or intravenous methotrexate to our preoperative regime. Chemotherapy is initiated during radiotherapy with careful monitoring of the white blood cell count, to note any early signs of toxicity. Prior to radiotherapy, the patient undergoes an

[†]Greater than 4 centimeters, ipsilateral node.



Figure 3-a — (Case Three) Patient with post operative micrognathia



Figure 3-b — (Case Three) Intraoral view after long course of postoperative mouth care and rehabilitation to remove osteomyelitic bone and provide mucosal covering of exposed bone.

evaluation by the dentist and oral surgeon since many of the patients with carcinoma of the head and neck have relatively poor oral hygiene and need multiple extractions. This is done immediately and a program of oral hygiene is instituted.

If the palate is to be resected, the patient will be evaluated by a prosthodontist. Molds will be prepared for an eventual permanent prosthetic appliance which will be fitted in its final form after the patient has fully healed from surgery.

Those patients undergoing laryngectomy are immediately referred to a speech therapy program to learn esophageal speech. Approximately sixty to seventy percent of the patients undergoing laryngectomy become adept at esophageal speech. The remaining are encouraged to use an electrolarynx.

Although our program has not been in force for a long enough period of time to provide a valid statistical analysis of the cure rate following the

combination of high-dose radiotherapy and radical surgery, certain trends are apparent and are worth reporting.

1. We seem to have a much higher percentage of patients with stages 3 and 4 carcinoma who have gone one year after surgery without evidence of recurrence of tumor. This is subjectively significant because our prior experience indicated that local recurrences usually manifested themselves within one year.

2. A number of patients with T3 and T4 (see table) lesions have had complete sterilization of the primary site by radiotherapy. This has been documented on the multiple sections of the operative specimen. There has usually been residual disease in the regional nodes. We feel this apparent radiotherapeutic cure of the primary lesion is an excellent prognostic sign and we are not concerned by the removal of some primary sites which have not contained viable tumor. Statistically, these far-advanced

T and N Classifications

T = Primary Disease N = Distant Metastases
Oral Cavity and Tongue

T 1 — Less than 2 centimeters

T 2 — 2 to 4 centimeters

T 3 — Greater than 4 centimeters

T 4 — Lesions extending beyond confines of the organ
Laryngeal

T 1 — Limited to vocal cord

T 2 — Extending vertically to supraglottic area above or below

T 3 — Horizontal extension with fixation of vocal cord

T 4 — Extension out of confines of larynx

Nodal

N 1 — Ipsilateral node

N 2 — Bilateral or contralateral node

N 3 — Fixed nodes

Stages of Oropharyngeal Carcinoma

Stage 1 — T 1	N 0	M 0
Stage 2 — T 2, 3	N 0	M 0
Stage 3 — T 1, 2, 3	N 1	M 0

lesions have not done well with radiotherapy alone. We are not comfortable in making a clinical assessment as to the presence or absence of tumor after radiotherapy to avoid surgery in those who may have had a radiation cure as reported by Constable, *et al.*⁵

3. The morbidity has increased only minimally and certainly has been acceptable for the promise of increased cure rates. We have encountered only occasional local wound breakdowns and no carotid artery "blowouts." The patient's hospital stay has been increased only by a few days; most patients are discharged between the eighth and fourteenth post-operative day.⁶

4. The rehabilitative aspect has markedly improved the patient's recovery. The patients are all presentable, can eat and communicate well. Many have been able to return to their former occupation.

5. The increased awareness by the medical community of the favorable results achieved by this team-approach seems to have led to earlier referrals. We feel this is related to the greater optimism of the referring physician and increased awareness of oropharyngeal symptomatology that should be evaluated carefully.

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Cause of Incorrect Value of Albumin in Hyperbilirubinemic Serum by SMA 12/60 Autoanalyzer®

J. Jacob, M.D. and K. P. Lance, M.D. Paterson*

In most hospitals, estimation of serum protein and serum bilirubin is routinely done by the Technicon SMA 12/60 Autoanalyzer.®* The results are usually comparable to other available methods. The other methods of estimation of serum protein and albumin are Bromcresol Green, Biuret, Haba dye, and protein electrophoresis. In protein electrophoresis, total protein estimation has to be done by another technique so that individual proteins can be determined by percentage from the paper strip. With the availability of the Autoanalyzer®, protein, albumin, and bilirubin are routinely determined by this machine, except under special circumstances. One of these special circumstances should be when the bilirubin level is high in the serum.

Reduced albumin levels in the hyperbilirubinemic serum have been reported previously.¹ The newer model of Autoanalyzer® has corrected the problem. This report is especially to re-emphasize this erroneously low albumin reading in jaundiced patients. In such instances, physicians may become unduly upset about low albumin level, not realizing that it may be erroneous in the presence of icteric serum, and consider albumin transfusion and postponing required surgical intervention.

Methods — Results

We routinely evaluated albumin, by protein electrophoresis and SMA 12/60, in eleven patients including a newborn baby who had hyperbilirubinemia (Chart I). All of the subjects, regardless of the etiology of the high bilirubin, had a low albumin reading. It did not make any

difference whether it was conjugated or unconjugated bilirubin. We found that the higher the bilirubin, the lower was the albumin, though no linear correlation could be plotted.

In order to reproduce this effect, we took normal serum and added hyperbilirubinemic serum and found the same effect (Chart II). The results are not very striking because of the relatively lower value of total bilirubin due to dilution. When we tried to do the same with commercially available bilirubin we failed, due to the high concentration of bovine albumin in the commercial bilirubin.

Discussion

This study definitely shows that the albumin value by SMA 12/60 can be erroneously low, if there is hyperbilirubinemia, and that very high bilirubin levels greatly diminished the albumin value. When bilirubin in serum is high, it is bound to albumin, and this bound albumin is not detected by the Haba dye method that is being used in the Autoanalyzer.® The new albumin-determination unit in the machine uses Bromcresol Green for the albumin determination, and hence bound albumin also is estimated. Whenever serum albumin is low in extremely icteric serum, it is important to have total protein and albumin estimated by Bromcresol Green technique or by one of the other available modalities of estimation, such as electrophoresis and the Biuret method. Not being aware of this "machine-error" can lead to many problems for the patient and the physician, e.g., valuable time may be lost if surgery is postponed due to "low albumin" value in patients with obstructive jaundice.

*From the Department of Gastroenterology, St. Joseph's Hospital and Medical Center, Paterson. Dr. Jacob is now at the Fairmont Clinic, Fairmont, West Virginia.

Chart I

Patient	SMA ₁₂ Bili	SMA ₁₂ Alb.	SMA ₁₂ T. P.	Electro T. P.	Electro Alb.	Diagnosis
1	19.6	1.8 (1.7)	8.8	8.8	3.5	Alcoholic Hepatitis
2	15.5	2.6 (1.5)	7.7	7.7	4.1	Infective Hepatitis
3	8.3	2.7 (0.9)	6.5	6.9	3.6	Serum Hepatitis
4	20	2.1 (1.4)	5.9	6.3	3.5	Infective Hepatitis
5	21	2.3 (1.4)	8.0	7.6	3.7	Infective Hepatitis
	12	3.1 (0.6)	7.8	7.6	3.7	
6	4.1	1.7 (1.2)	7.0	6.4	2.9	Obstructive Jaundice with second biliary Cirrhosis
7 on admission	0.5	3.5 (0.2)	6.0	6.5	3.7	
10 days after admission	7.0	3.0 (0.5)	5.5	5.5	3.5	Ca Pancreas
14 days after admission	10.8	2.0 (1.5)	5.5	5.6	3.5	
8	17.7	1.1 (1.1)	7.7	6.8	2.2	Alcoholic Hepatitis
9 (newborn)	10.0	2.0 (1.1)	4.2	4.2	3.1	Rh incompatibility Hemolysis
10	28.2	0.8 (2.2)	7.1	6.8	3.0	Obstructive Jaundice
11	29.6	0.5 (2.1)	7.4	7.5	2.6	Obstructive Jaundice

Bili — Bilirubin in milligrams percent

Alb. — Albumin in grams percent

T. P. — Total Protein in grams percent

Electro — Electrophoresis

SMA₁₂ — SMA12/60 auto analyzer

The numbers in parenthesis are the difference between normal and the erroneously low volumes of albumin.

Chart II

Normal Serum (SMA ₁₂)			Normal Serum (Manual)			Hyperbilirubin (SMA ₁₂)			Hyperbilirubin (Manual)			Mixed Serum (SMA ₁₂)			Mixed Serum (Manual)		
Alb	Bili		Alb	Bili		Alb	Bili		Alb	Bili		Alb	Bili		Alb	Bili	
1	4	0.6	4.1	0.8		3.3	9.0		4.1	9.6		3.5	3.9		4.0	4.2	
2	4.5	0.7	4.8	0.8		1.8	36.0		2.2	34.0		3.0	10.3		4.1	9.9	
3	4.0	0.5	3.9	0.5		2.5	15.0		2.8	21.7		3.2	5.4		3.6	5.1	
4	4.0	0.5	3.9	0.5		2.7	19.0		2.6	20		3.6	7.3		4.1	6.7	

Alb — Albumin in gram percent

Bili — Bilirubin in milligrams percent

SMA₁₂ — SMA12/60 auto analyzer method of determination of serum Albumin

Manual — Manual method of determination of serum Albumin — Bilirubin

We understand from the distributors of Technicon SMA 12/60 Autoanalyzer® that most of the hospitals in New Jersey have their machines and about one-third of them still use the unit which uses Haba dye for estimation of bilirubin. The rest of the hospitals have changed their bilirubin estimation unit in their analyzers to Bromcresol Green.

Summary

We have reported the erroneously low value of albumin in hyperbilirubinemic serum when estimated by SMA 12/60 Autoanalyzer,® which utilizes Haba dye for albumin determination. We recommend other ways of determining albumin and total protein to obtain a correct

value when the patient is jaundiced.

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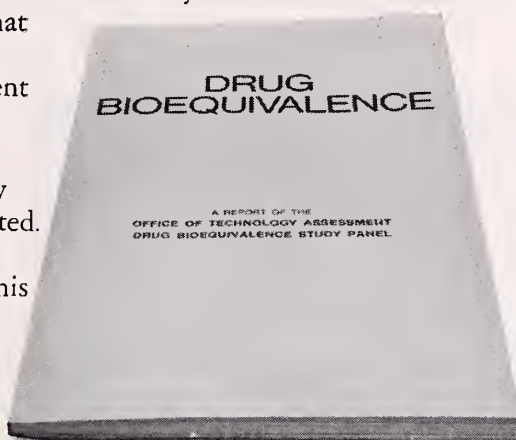
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuation (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Use with caution in alcohol-addicted or addiction-prone individuals under care.

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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Thirty-seven resting neonates were subjected to 1,200 tests to ascertain their startle responses to eleven external stimuli. These stimuli were: a bell, a whistle, intermittent and continuous white sound, light flashes, a suddenly expanding air mattress under the neck, spine or buttock, a cold air stream, and touch. During the first 24 hours post-partum, only a loss of equilibrium induced by a suddenly inflated air mattress under the infant would universally elicit a startle response. After one day post-partum, all neonates continued to respond to the air mattress. The response of 2-day old and older neonates to other stimuli was variable. Some would now be startled by light flashes and remain oblivious to various sounds, whereas others would respond only to sound.

The Development of Individuality in Neonates

Startle Reactions to Various Stimuli

Ulrich A. Frank and Peter Frank Cranbury

Apneic infants often require external stimulation to restart breathing, if damage is to be avoided. The use of commercially available pediatric monitoring devices has not always been successful.¹ In part, the difficulty with these devices lies in the lack of correlation between apneic spells and other vital signs such as heart rate;² or events, such as meals.³ This lack of collaborating events has been confirmed during the authors' work. This study explores various stimuli that may be incorporated into an automatic stimulation device triggered by a new monitor.

A survey of the literature revealed some of the techniques used to stimulate neonates. Steinschneider² employed various sound levels; Goodlin⁵ uses a cold air stream directed at sensitive areas; Wallace⁶ uses a flashing light; and Frank⁷ summarizes the results of other techniques. Some of these techniques were judged inherently unsuitable for automatic stimulation. For instance, the commonly employed method of rapping the incubator hood, if automated, would be annoying to the medical staff and slapping the sole of the neonate's foot is difficult to implement safely. Eleven stimulation methods were designed and compared for their efficacy. The most significant findings were that during the first day post-partum, a loss of equilibrium provides a reliable way to stimulate. Very few reactions are prompted by a variety of other

stimuli. After the infants are over a day old, they will selectively startle-react to several stimuli. For example, some will react to noise and not to light; others to light and not to noise; thereby exhibiting real personality differences.

Methods and Materials

The study deals with 37 infants in a neonatal nursery at St. Vincent's Hospital, New York. More than half were low birth weight infants. The older half (beyond 5 days post-partum) had some pathology. About one-third were male; about one-third were Caucasian. Their ages varied from 2 hours to 60 days and three were beyond the neonatal age.

All infants were asleep and free of distress at the time tested. Each stimulus was applied three times to each neonate studied with the sequence of application being varied. The response was evaluated by observation, in most cases by the consensus of two observers. Reaction to the stimulus was positive if at least two body parts moved during any one of three trials. Occasionally, the reactions were much more pronounced, resulting in a fully alert or crying infant. Testing was then temporarily discontinued.

*From the Department of Biomedical Research, Roche Medical Electronics Division, Hoffmann-La Roche Inc., Cranbury, New Jersey. Peter Frank is Medical Director, Continental Medical Services, Philadelphia.

Eleven stimulation devices were tried:

1. Visual stimulus: flashing light — A 40-watt bulb, with reflector, was positioned about one foot from the neonate's eyes and flicked on for about one second.

2. Auditory stimulus: continuous high sound — A Mallory Sonalert® emitting a steady 2900 Hz sound at 92 db was placed about one foot from the head.

3. Auditory stimulus: intermittent low sound — A Mallory Model SC628P, emitting a pulsed 2900 Hz sound at 82 db, was positioned about one foot from the head.

4. Auditory stimulus: intermittent high sound — A buzzer emitting white sound at 92 db was positioned about one foot from the head.

5. Auditory stimulus: bell — A doorbell, mounted within a metal box to reduce the sound intensity to 92 db, was positioned about 1 foot from the head. The bell was audible for one half to one second.

6. Auditory stimulus: whistle — A whistle, emitting a sound of about 96 db, was positioned about one foot from the head.

7. Thermal stimulus: cold air stream—A jet of cold air was directed at a sensitive area, generally the abdomen or groin, for about one second.

8. Mechanical stimulus: balloon alongside patient—A segmented air mattress, connected to a 4 psi pressure source by means of a tube with an internal diameter 1/4 inch and 5 feet in length and capable of full inflation in less than 1/2 second, was placed alongside the infant in the incubator touching the infant when inflating. The balloon was about 10 inches long and 2 inches wide. Uninflated, the thickness was 1/8 inch. When inflated, it expanded to 1-1/2 inches in thickness and then returned rapidly to its original thickness upon deflation.

9. Mechanical stimulus: balloon under spine—The mattress, described above, was placed under the infant's spine so that rapid inflation and deflation raised and lowered the midsection of the patient.

10. Mechanical stimulus: balloon under buttock — The mattress, described above, was placed under the infant's buttock so that rapid inflation and deflation raised and lowered the hips of the patient.

11. Mechanical stimulus: balloon under neck — The mattress described above, was placed under the infant's neck so that rapid inflation and deflation produced a momentary arching of the neck in relation to the head and thorax.

Results

Table 1 shows the result of over 1200 tests, comparing 11 different stimuli on 37 resting neonates.

The superiority of sudden elevations, caused by a rapidly expanding air mattress under the infant, in eliciting responses, appears clear in both age groups. The less-than-one-day-old group did

not react to stimuli other than the three elevations, caused by the rapidly expanding air mattress. Among the more-than-one-day old group, cold air streams directed at sensitive areas, seemed about as effective as the bell, high and continuous sounds and light flashes. Low sounds and the whistle were a poor second.

The only mechanical method that proved totally ineffective was placing the balloon alongside the patient. The degree of stimulation this tactile sensation provided is probably too gentle. However, it likely indicates that the effectiveness of the other balloon initiated reactions is due to induced body motion, rather than some secondary effect, such as the noise of air rushing in or valve sounds.

Table 2 groups reactions between those younger and older than one day. There is an increase in the number of stimuli to which these infants reacted after one day.

Four apneic infants were tested using the sudden elevation by balloon. The results are given in Table 3. In 105 trials, there were 99 successful terminations of apneic episodes. These episodes were automatically sensed and then terminated by the rapidly expanding air mattress-under-the-infant method.

Discussion:

Following the development of an apnea monitor, the Roche Medical Electronics Division of Hoffmann-LaRoche decided to "close the loop" and design a device that would arrest the apneic episode. This device would be actuated prior to the nurse's intercession. In order to ascertain the most effective stimulus to be employed in such a device, various stimuli were tried.

The population tested was too small to formulate many conclusions about any selective effects, as to differences among size, sex, and race. To say there was no reaction, in the case where body movements were absent, is to overstate the case. There may have been changes in EEG patterns, but such reactions were outside the range of our experiments. *The reactions did indicate that various neonates would react to some and not others of the stimuli tested.* Every

Table I
Comparison of Stimuli Effectiveness

Individual No.	Age: Hours/Days	Sex	c = Caucasian Race	b = Black Cold Air	Balloon Alongside	Balloon under Spine	Balloon under Buttock	Balloon under Neck	Whistle	Bell	Sound Inter- mittent	High Low	Sound Continuous	Light Flash	
3	2 Hrs	m	b	—	—	x	x	x	—	—	—	—	—	—	repeat
3	3 Hrs	m	b	—	—	x	x	x	—	—	—	—	—	—	
2	2 Hrs	f	c	—	—	x	x	x	—	—	—	—	—	—	
20	3 Hrs	f	b	—	—	x	x	x	—	—	—	—	—	—	
25	4 Hrs	f	b	—	—	x	x	x	—	—	—	—	—	—	
7	4 Hrs	f	c	—	—	x	x	x	—	—	—	—	—	x	
37	5 Hrs	f	c	—	—	x	x	x	—	—	—	—	—	—	
26	5 Hrs	f	c	—	—	x	x	x	—	—	—	—	—	—	
34	8 Hrs	f	c	—	—	x	x	x	—	—	—	—	—	—	
33	1 Day	f	b	—	—	x	x	x	—	—	x	—	x	—	
1	2 Days	f	b	—	—	x	x	x	x	—	—	—	—	x	Retest of 2/Hr old
16	2 Days	f	b	—	—	x	x	x	—	—	x	—	x	—	
4	3 Days	f	b	—	—	x	x	x	—	x	—	—	—	—	
3	3 Days	m	b	—	—	x	x	x	—	x	—	—	—	—	
21	3 Days	m	b	—	—	x	x	x	—	—	—	—	—	—	
27	3 Days	f	c	—	—	x	x	x	x	—	—	—	—	—	
22	5 Days	f	b	x	—	x	x	x	—	x	—	—	—	—	
9	5 Days	f	c	—	—	x	x	x	—	—	—	—	—	—	
31	8 Days	m	c	—	—	x	x	x	—	x	x	—	x	x	
23	8 Days	m	c	—	—	x	x	x	—	—	x	—	x	—	
12	9 Days	m	c	—	—	x	x	x	—	—	—	—	x	x	x = Response
18	10 Days	f	b	x	—	x	x	x	—	—	x	x	x	—	
24	10 Days	m	b	x	—	x	x	x	—	x	—	—	—	—	
30	11 Days	f	b	x	—	x	x	x	—	—	x	x	x	—	
19	12 Days	m	b	—	—	x	x	x	x	x	—	—	—	—	
10	12 Days	f	b	—	—	x	x	x	—	—	x	x	x	—	
36	13 Days	f	b	—	—	x	x	x	—	—	—	—	—	—	
15	14 Days	f	b	x	—	x	x	x	—	—	—	—	—	x	
13	14 Days	f	b	—	—	x	x	x	—	—	—	—	—	—	
35	16 Days	f	c	x	—	x	x	x	—	—	—	—	—	x	
11	18 Days	f	c	—	—	x	x	x	—	x	—	—	—	x	x = Response
32	19 Days	f	b	x	—	x	x	x	—	x	—	—	x	—	
29	28 Days	m	c	—	—	x	x	x	—	x	—	—	—	x	
14	29 Days	f	b	x	—	x	x	x	—	x	—	—	—	x	
8	32 Days	m	+	—	—	x	x	x	—	x	—	—	—	—	
17	56 Days	m	b	—	—	x	x	x	—	—	—	—	—	x	
5	60 Days	f	+	—	—	x	x	x	—	—	—	—	—	x	

x = Response

stimulus, except the gentle touching induced by the "balloon alongside," would induce a reaction in some of the neonates. However, some of our infants would not react to some of the stimuli, while reacting to others, indicating real *individual differences* among them, after the first day post-partum.

While there is no data for infants between eight hours and twenty-four hours old, a comparison of the younger and older group shows a remarkable increase in awareness of the external

world during that period. At the outset of the clinical evaluation of resting neonates, a most immediate question was whether or not the production of a startle response in resting newborns was analogous to the reinitiation of breathing in the apneic infant.

Crosse⁸ notes that reaching a hand under the back at chest level, and lifting, so that the chest is briefly arched forward until the spine is well extended and then releasing, "almost invariably precipitates an inspiratory effort" when simple

Table 2
Percent Response to Stimuli

Stimulus	Age	
	Less than One Day	One or More Days
Cold Air	0	28
Balloon Alongside	0	0
Balloon Under Spine	100	100
Balloon Under Buttocks	100	100
Balloon Under Neck	100	100
Whistle	0	11
Bell	0	39
Intermittent High Sound	0	25
Intermittent Low Sound	0	11
Continuous Sound	0	32
Light Flash	4	11

Table 3
Clinical Results with Automatic Apnea Arrestor

Patient	No. Episodes Successfully Terminated	No. Episodes Requiring Nurse Intervention	Total Episodes
Female "S"	19	0	19
Male "F"	64	6	70
Male "J"	8	0	8
Male "B"	8	0	8
Totals	99	6	105

rapping on the incubator fails. Rossier⁹ recommends the use of a cushion which elevates the shoulders and places the head in slight hyperextension to increase respiratory activity. The efficacy of the suddenly expanding balloon method tested here would appear to signify that the balloon-under-neck method is not only an effective form of mechanical stimulation, as shown in the comparative tests, but also that the momentary postural change produced in the infant may in itself be conducive to respiration.

Conclusions

1. During the first day of life, the great majority of neonates will startle react to sudden change in position and no other external stimuli.

2. There is a greater awareness of outside events after the first day post-partum

3. Reactions of infants to external stimuli vary after the first day post-partum.

4. After the first day post-partum, some neonates will react to sound while remaining oblivious to light flashes; others react to light and are not stimulated by sound.

5. After the first day post-partum, the majority of neonates will react to a sudden change in elevation.

6. The sudden elevation is an effective arrestor of apneic episodes.

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3. Stock, J.M., Surks, M.I., and Oppenheimer, J.H.: Replacement dosage of L-thyroxine in hypothyroidism. A re-evaluation. New Engl. J. Med. 290:529-33, 1974.

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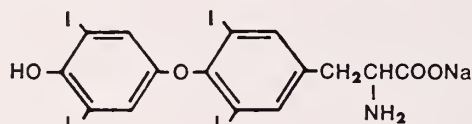
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Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) Tablets, the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) Tablets daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdose per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

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In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

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CASE REPORTS

Wilms' tumor is rare in adults. This case report and discussion illustrate the difficulty in diagnosis unless one keeps the clinical, radiographic, and angiographic criteria in mind.

Adult Wilms' Tumor

An Appraisal of Radiographic and Angiographic Features

Elviro Bernas, M.D. and William E. Matthey, M.D./Livingston*

Wilms' tumor (Nephroblastoma among fifty synonyms) is a sarcoma of a mixed embryonal origin derived from the metanephrogenic blastema. First described by Wilms in 1899, it rarely occurs in adults although it has been reported in octogenarians⁶ and in the fetus. Wilms' tumor accounts for eight percent of renal malignancies in all age groups.⁹ Eighty percent of cases occurs below five years of age, sixty-five percent below three years.

This case report stresses the need for awareness of its occurrence in adults and the difficulty in diagnosis if one is unfamiliar with its clinical and radiographic features.

A 25-year-old male had left upper quadrant pain associated with a palpable mass and microscopic hematuria discovered ten weeks before hospitalization. One week before admission he had gross hematuria. Two days later an excretory urogram in a radiologist's office showed a mass in the lower pole of the left kidney with diminished function. It was interpreted as a cyst. The patient had had Friedlander's pneumonia one week prior to this illness. Physical examination revealed a well-nourished individual with a blood pressure of 170/110 and pulse rate of 92/minute. There was a firm, smooth and non-tender mass palpated in the left upper quadrant. Hematocrit was 57.6 percent, hemoglobin 19.9 gm./100ml., RBC 6,800,000/cu.mm. The urine was yellow, clear, with pH 5.5 and specific gravity 1.023. It had numerous red blood cells, but was otherwise negative. SMA 12 was normal except for LDH which was 365 mu per ml. Electrocardiogram was normal. Chest x-ray was negative except for tenting of the right hemi-diaphragm.

Retrograde pyelogram (Figure 1) revealed the left collecting system to be dilated, distorted and displaced by a mass. The ureter was slightly displaced medially. Renal arteriogram (Figures 2 and 3), demonstrated a characteristic angiographic pattern as described below. Liver scan and skeletal survey were negative.

The left kidney, after radical nephrectomy, was found to measure 18 x 12 x 9 cm.; it weighed 1,420 grams with the attached perirenal fat. There was penetration and breakthrough of the capsule and invasion of the renal pelvis and vein by tumor. The surface was multilobulated and greyish-

pink and the cut surface showed areas of hemorrhage and necrosis.

The patient's post-operative course was uneventful except for a drop in hemoglobin to 8.5 gm. percent. Without transfusion, the hemoglobin rose to 11.7 gm. percent and hemocrit to 33.5 percent before discharge.

Discussion

Wilms' tumor is usually encapsulated, but as it grows the capsule is perforated with invasion of the renal parenchyma and perinephric tissues. Hematogenous metastasis to the lungs is common, less frequent to the liver and rare to the



Figure 1 — Retrograde pyelogram shows a mass in the lower pole area displacing and distorting the collecting system. The upper ureter is deviated medially.

*This case report is from the Department of Radiology of St. Barnabas Medical Center, Livingston, where Dr. Bernas is Associate Attending in Radiology and Dr. Matthey is Director of the Department



Figure 2 — Renal arteriogram, arterial phase, shows tortuous, corkscrew vessels with sharp-angulated bends with abrupt changes in calibre (upper arrow). There are also thin and attenuated "spider-leg" vessels (lower arrow).



Figure 3 — Late arterial phase illustrates further the thin, "spider-leg" vessels with microaneurysms at the sharp bends (arrows). Note the large avascular area not reached by the elongated and attenuated tumor vessels. There was delayed tumor circulation.

bones, in contradistinction to neuroblastoma. Less frequent sites of metastasis are the peritoneum, brain, spleen, adrenals, ipsilateral ureter and bladder.⁴ The majority of Wilms' tumor can be diagnosed by clinical and urographic criteria. In half the infants with an abdominal mass or enlargement, it is due to a urinary lesion; the most common cause is hydronephrosis and the next is Wilms' tumor.⁸ Among abdominal malignancies, Wilms' tumor is slightly less common than neuroblastoma, which is not of urinary origin.

Clinical Findings

The prevalent clinical findings in Wilms' tumor are: palpable mass, 90 percent; hypertension, 60 percent; pain, 20 percent; anorexia, nausea and vomiting, 16 percent; fever, 10 percent; and gross hematuria, 6 percent (this occurs in seventy to eighty percent of hypernephromas).¹⁰ Curvilinear or punctate calcifications are seen by x-ray in 10 to 12 percent of cases.¹¹ Four to 10 percent have bilateral disease;^{1,10} in cases with Wilms' tumor bilaterally, it is present simultaneously in 65 percent; in the others, the opposite kidney is involved in from three weeks

to ten years' time.³ Associated findings are hypospadias, undescended testes, horseshoe kidney, ureteral and renal duplication, hypoplastic and aplastic kidney, ureteral anomalies, aniridia, cataracts, mental retardation, small head circumference and hemangiomas.

X-ray Findings

Radiographically, the plain film may show a renal mass or abdominal enlargement with bowel displacement, when the tumor is large. The psoas shadow may be obliterated. The renal pelvis or calyces, or both, may be distorted, displaced or cut-off. The normal kidney may be displaced into the periphery of the mass. At times it can simulate a cyst. Compression and displacement of the ureter and calcification may be present, although they are more commonly seen in neuroblastomas. There may be invasion of the renal pelvis, ureter and renal vein or inferior vena cava resulting in a nonfunctioning kidney in 16 percent of cases.⁷ In these instances, it may be feasible, especially in infants and children, to do the excretory urogram by injecting contrast medium into the femoral or saphenous vein to

obtain an inferior vena cavagram at the same time.⁵

In 20 to 30 percent of cases, the diagnosis may be doubtful.² Arteriography should be done in these patients, especially if pre-operative radiotherapy or chemotherapy is being contemplated. Abdominal aortogram and selective renal arteriogram, besides confirming the presence of neoplasm, provide clearer delineation of the extent of the tumor. Arteriography also shows bilaterality, presence or absence of metastasis in the liver and response to, or recurrence after, therapy. The selective technique is preferred because large avascular areas are common within the tumor and abdominal-flush may fail to opacify the diagnostic details.

Angiographic Criteria

There are characteristic angiographic criteria for the diagnosis of Wilms' tumor, although they are not specific. Cremin and Kaschula² were able to diagnose 13 cases of Wilms' tumor pre-

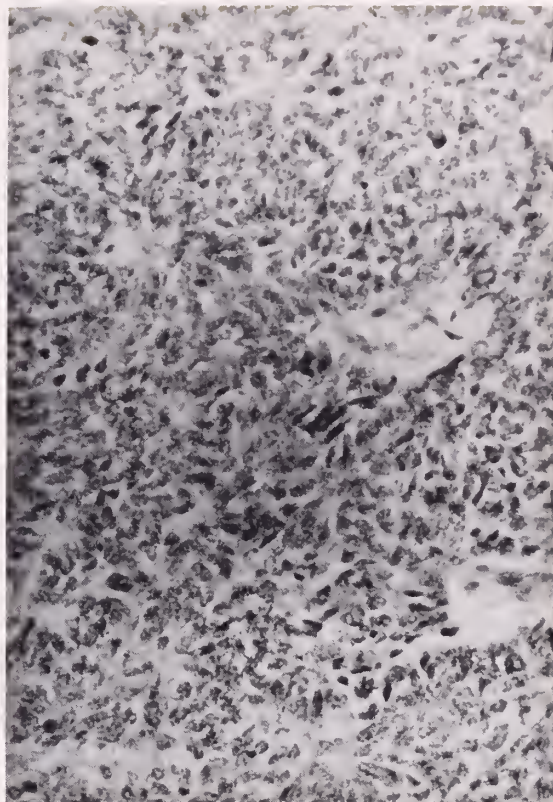


Figure 5 — Microscopic-Wilms' tumor showing embryonic type of connective tissue with vague rosette formation (magnification x 100).

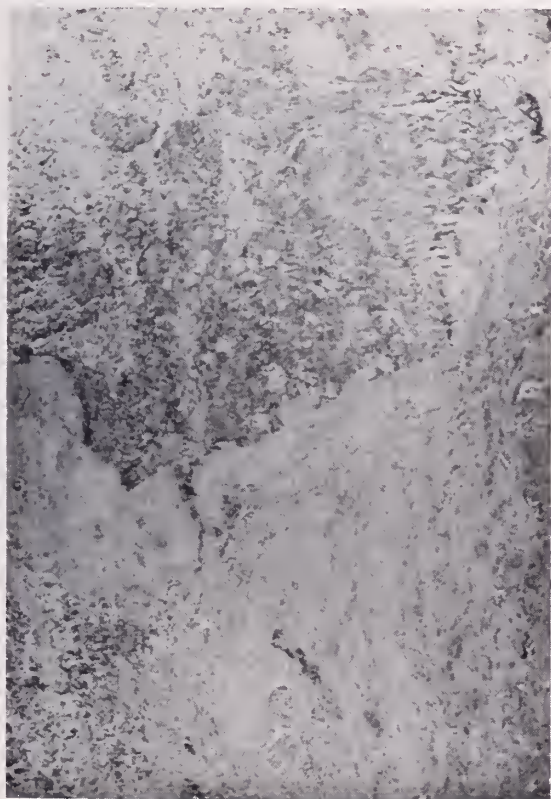


Figure 4 — Microscopic-Renal parenchyma partly replaced by Wilms' tumor in upper half (low power, x 10).

operatively. The only error occurred in a case of renal dysplasia or multicystic kidney; this is not surprising if one realizes that the tumor is due to heteroplasia of primitive renal tissue or developing kidney like in Wilms' tumor. The angiographic features consist of thin, elongated and attenuated "spider leg" vessels with sharp-angulated bends, tortuous, corkscrew vessels with twisting patterns, abrupt changes in caliber of vessels with micro-aneurysms at the sharp bends, large avascular areas, delayed circulation in dilated tumor vessels lasting three to four seconds, collateral circulation especially from lumbar arteries and some arteriovenous shunting. The first two or three features are the most important.

Differential Diagnosis

Among the differential diagnoses, hydronephrosis, neuroblastoma, ganglioneuroma, perinephric abscess, renal cyst, multi-cystic kidney, leukemic infiltration and lymphoma may be considered. These can usually be

differentiated by clinical, urographic and angiographic criteria. Hydronephrosis is sometimes mistaken for Wilms' tumor, particularly in children, when it presents as an abdominal mass and is bilateral. It can usually be diagnosed on delayed films and nephrotomogram by the smooth or symmetrical dilatation of the renal pelvis, calyces and ureter, without displacement or distortion, and by the symmetrical thinning of the renal parenchyma. On angiography, there is characteristic displacement and stretching of the renal branches and radiolucent outline of dilated pelvis and calyces during the parenchymal phase.¹⁶ Neuroblastoma,¹⁶ which is essentially an extrinsic or extra-renal mass, produces "angular displacement" of the kidney without distortion of the collecting system, except when large. Calcification, which is about 50 percent more common in neuroblastoma than in Wilms' tumor, is characteristically stippled; it may be present in metastasis, for instance in the liver. Metastasis to bones usually causes pain or anemia, which often brings the patient to the physician. Neuroblastoma exhibits a very rapid circulation with thin vessels of a uniform caliber, occasionally with arteriovenous shunting, in contradistinction to the slow circulation of Wilms' tumor with large avascular areas.² Presence of

catecholamine metabolites¹² (vanillyl mandelic acid and metanephrines) enhances the accuracy of diagnosis to 95 percent.¹³ Ganglioneuroma, which is also extra-renal, is generally avascular. Malignant neuroblastoma may undergo a "maturation phase" into benign ganglioneuroma, either spontaneously or during treatment.¹⁴

Perinephric abscess and renal cyst are readily recognized by history, physical and radiologic findings. In perinephric abscess, a tender perirenal mass with mottled gas collection may be encountered. Renal function is usually present and the internal renal architecture is not disturbed. Leukemia or lymphoma may enlarge one or both kidneys, with stretching of the calyces. However, other organs or systems may be involved — hepatosplenomegaly, enlargement of abdominal, mediastinal, cervical, axillary or inguinal nodes. Angiographically, a multicystic kidney may simulate a nephroblastoma as noted by Cremin and Kaschula.² Multicystic kidney, which is commonly seen in infants and children, is unilateral and shows no function. The involved kidney may calcify in two or three loculated grape-like cystic areas. If the ureteral orifice can be found, on retrograde pyelogram,¹⁶ the ureter is either absent or atretic.

Old Short Hills Road

Study of Operative Treatment of Patients with Valvular Disease

Cooperation of physicians is requested in the referral of patients for studies of the operative treatment of patients with valvular disease being undertaken at the National Institutes of Health Clinical Center in Bethesda, Maryland, by the National Heart and Lung Institute.

Over 1,000 patients have had aortic and/or mitral valve replacements at the National Heart and Lung Institute. Most patients benefit, but some do not achieve significant functional improvement despite excellent mechanical results. To utilize effectively the data accumulated at the Institutes so that decision regarding the advisability of operation can be made in as in-

formed a way as possible, the Cardiology and Surgical Branches are conducting an in-depth prospective study designed to identify clinical and hemodynamic indices that would reliably suggest operative prognosis and allow identification of the patient with irreversible myocardial changes.

Patients accepted will be admitted to the Clinical Center for evaluation; surgery will be performed if indicated. There is no charge for the services. Physicians may refer patients' case summaries to Stephen E. Epstein, M.D., National Institutes of Health Clinical Center, Room 7B-15, Bethesda, Maryland 20014.

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Overwhelming postsplenectomy infections, frequently due to pneumococcus and occasionally associated with disseminated intravascular coagulation, have been previously reported. The unusual feature of this case is the 21-year lag between splenectomy and the fatal sepsis.

Fatal Pneumococcal Septicemia with Disseminated Intravascular Coagulation Following Splenectomy

Peter A. Lodewick, M.D.
Moorestown

Pneumococcal septicemia has been established as a complication of splenectomy.^{1, 2} The following case report describes a patient with a twenty-one year interval between splenectomy and the development of pneumococcal septicemia with disseminated intravascular coagulation.

Case Report

A 43-year-old woman had the sudden onset of chills, weakness, and sore throat fourteen hours prior to hospitalization. She became nauseated, vomited several times, and had one bowel movement. Her husband noted that she was intensely cyanotic and had purple spots scattered over her face, upper thorax, and legs. She was immediately brought to the hospital for evaluation.

Past history included severe anemia of unknown kind at age 21; she was treated with multiple blood transfusions and a splenectomy. She subsequently had three full-term, uncomplicated pregnancies. Aside from her pregnancies and splenectomy, she had no other hospitalizations. Review of systems was negative for any significant symptoms. On admission, the patient was in marked distress; she was restless and complained of weakness and intense burning of her legs. Temperature was 100° F. (37.8° C) rectally. Femoral pulse was 110 per minute. Multiple ecchymotic and petechial lesions were distributed over the whole skin surface. There was bleeding noted in the oropharynx and perianally. The thyroid, lymph nodes, chest, and heart were normal. The abdomen was slightly protuberant with diffuse deep tenderness and hypoactive bowel sounds, but neither abdominal masses nor the liver were palpable. Rectal was normal except for bright red blood on the rectal glove. The extremities appeared intensely cyanotic and felt extremely cold; subungual splinter hemorrhages were visible.

Laboratory tests: Hemoglobin 15.2 Gm. per 100 ml, hematocrit 49, WBC 26,401, with 76 percent polymorphonuclear cells, 9 bands, 16 lymphocytes. Prothrombin time was over 200 seconds, partial thromboplastin time over 300 seconds, platelet count 24,000, fibrinogen 10 mg. per 100 ml., BUN 27 mg. per 100 ml., creatinine 3.5 mg. per 100 ml., CO₂ 14.3 mEq./l., K 4.1 mEq./l., Na 135 mEq./l., Cl 95 mEq./l. Chest x-ray was essentially normal. EKG showed non-specific ST-T wave changes and VPCs. Blood culture was positive for pneumococcus pneumoniae.

Hospital Course: The patient was treated for possible pneumococcal septicemia with 5,000,000 units of penicillin intravenously within one hour of admission and every six hours thereafter. She was given adrenalin, levophed, and hydrocortisone intravenously, blood transfusions, heparin, and fresh frozen plasma for treatment of shock and diffuse intravascular coagulation. She did not respond to any of the above treatment and died within 18 hours of admission.

Summary of post-mortem findings: The subject was a well-nourished white female, whose skin on the face, chest, and upper arms contained purpuric spots measuring one centimeter or smaller. Two small subepicardial hemorrhages were noted near the cardiac apex. Diffuse subpleural petechial hemorrhages were found throughout both lungs, grossly, while microscopic section showed focal hemorrhage. Microscopic sections of the liver disclosed irregular congestion, focal hemorrhage, and necrosis. The spleen had been removed previously. Both adrenals were moderately enlarged and on microscopic section showed diffuse hemorrhage. The kidneys weighed 200 grams (right) and 170 grams (left) and were studded by hemorrhages in both the mucosa of the pelvis and in the peripelvic fat. Microscopically, one small blood vessel showed a fibrin mass. The intestinal wall contained small and moderately extensive hemorrhages. The diagnosis was pneumococcal septicemia.

Discussion

Remarkable in this patient was the 21-year gap during which she enjoyed excellent health, had three uncomplicated pregnancies, had no significant hematologic disorders, and had no significant infectious illnesses.

Pneumococcal septicemia, as a complication of splenectomy, is most likely to occur in post-splenectomy patients with Cooley's anemia or aplastic anemia. It is less frequent in patients with primary hypersplenism, and rare in normal persons after splenectomy for ruptured spleen.^{1, 2} If pneumococcal sepsis is to occur, it tends to appear within two to three years after splenectomy.^{1, 2} The cause for this complication of splenectomy is not known. Patients with Hodgkin's lymphomas may be more predisposed because of the added factors of

radiation, chemotherapy, immunosuppression or hypogammaglobulinemia, while victims of aplastic anemia are susceptible to infection for obvious reasons.

The propensity of patients with Cooley's anemia to this problem has not been sufficiently explained. Constantoulakis, *et al.*,³ recently reported a series of 72 patients with Cooley's anemia in whom there was a significant fall in IgM immunoglobulins after splenectomy, with lowest levels occurring six months post-operation. The IgM levels then gradually increased to reach the pre-splenectomy level two to four years later. This might account for the increased susceptibility to pneumococcal sepsis because IgM antibodies react against mucopolysaccharide antigens found on the pneumococcal and other gram-positive bacterial cell walls. It would be of interest to see if IgM levels fall in other post-splenectomy conditions.

Summary and Conclusions:

A case of fatal post-splenectomy pneumococcal septicemia with disseminated intravascular coagulation is reported. Particularly striking was the twenty-one years in which the patient enjoyed good health. The reasons why post-splenectomy patients are susceptible to fatal sepsis remain obscure. It would seem prudent to watch carefully post-splenectomy patients for infection.

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155 East Third Street

Surgery in the Post-Infarction Patient — William Eric Scott, M.D.*

Whenever the possibility of surgical intervention upon a patient who has previously sustained a myocardial infarction is raised, it is essential to review the existing data on such patients with regard to the likelihood of re-infarction.

Any patient who has already had a heart attack will always be more likely to have a post-operative infarction than the rest of the surgical population. This increased risk, however, which is greatest for surgery immediately following an infarct, lessens with the passage of time and finally settles out about two years post infarct. During the first six-month period about 50 percent of those operated upon will sustain a re-infarction and approximately 60 percent of these will die as a result.

These are averaged figures for this time period, and since it is clear that the risk is higher in the first three months than in the second, only surgery of a most urgent nature should be countenanced during the former period, and

every consideration should be given to postponing surgery for six months following a myocardial infarction. Between six months and two years following a heart attack, the risk of post-operative recurrence falls from about 25 percent to five percent, and then stabilizes at about this latter figure. Accordingly, when any proposal for surgery is under consideration upon a post-infarctional patient, an attempt should be made to determine the risk of postponing the operation so that this can be compared with the known risks of surgery in these patients.

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- *From "The Cooper Review" published by The Department of Medical Education, Cooper Medical Center, Camden, New Jersey, where Dr. Scott is Chief Attending, Department of Anesthesiology.



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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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The safety of ethaverine hydrochloride during pregnancy or lactation has not been established; therefore it should not be used in pregnant women or in women of childbearing age unless, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

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The following case study of a Middlesex County, New Jersey, resident illustrates the effective treatment of familial Mediterranean fever (FMF) with colchicine therapy. A thirty-five year old male of Italian ancestry was treated with an average dosage of 0.6 mgs. b.i.d. During ten months of colchicine treatment, for which twenty attacks were anticipated, none occurred. There were no adverse side effects of colchicine other than occasional mild diarrhea.

The Use of Colchicine for the Treatment of Familial Mediterranean Fever

**Man Wah Cheung, M.D. and
A. C. Pugliese, Ed.D./Metuchen**

Familial Mediterranean fever (FMF), a disease of uncertain pathogenesis, is characterized by recurrent, disabling attacks of fever and polyserositis which most often resemble acute peritonitis. It is prevalent in peoples of Mediterranean stock, particularly Sephardic Jews and Armenians.^{1, 2} In addition, cases which seem clinically indistinguishable from familial Mediterranean fever are sometimes encountered in persons of quite different ethnic background.³ Until recently no uniformly successful therapeutic measure had been made available. Cholecystectomy, low fat diet, corticosteroids, psychotherapy, diphenylhydantoin, and anovulatory steroid therapy had all been tried, but nothing seemed able to reduce the frequency or intensity of attacks in FMF victims.

In 1955, Mamou⁴ wrote that colchicine was beneficial in the treatment of a patient with the "articular" form of familial Mediterranean fever. In 1967, Sohar, *et al.*⁵ stated that colchicine was of no value for patients with the disease, however their experience did not include the prophylactic use of this drug.⁶ Other reports of failure with colchicine were published by Hovsepian,⁷ Reimann,⁸ and McKinney.⁹

In 1972, Goldfinger¹⁰ reported that the daily administration of colchicine prevented attacks in five patients. Eliakim and Light¹¹ noted that patients maintained on 0.5 to 1.5 mg daily seemed to enjoy a remarkable decrease in the number of attacks experienced. Hassan, *et al.*¹² and Manialawi,¹³ in Egypt, also had similar success with colchicine.

In 1974 Zemes, *et al.*¹⁴ confirmed the advantage of colchicine in decreasing acute attacks of FMF in a double-blind, crossover study of twenty-two patients. The regimen consisted of either 0.5 mg of colchicine or an identical-appearing placebo, twice daily for two months, followed by two additional months of the other treatment. Thus each patient served as his own control.

More recently Dinarello, *et al.*¹⁵ studied eleven patients with long standing FMF in a double-blind trial using daily colchicine or placebo. During sixty courses of placebo, thirty-eight attacks of FMF occurred. In contrast, during sixty courses of colchicine only seven attacks occurred ($p < 0.001$, by chi-square test). The seven attacks on colchicine were evenly distributed throughout the study period. Three of these occurred shortly after colchicine was temporarily discontinued. In addition, four patients who noted mild prodromal symptoms characterized by abdominal discomfort, found they were able to abort full-blown attacks simply by taking an additional colchicine tablet. This study demonstrates that daily colchicine is highly effective in preventing attacks in FMF.

The following case study of a Middlesex County, New Jersey, resident illustrates the effective treatment of FMF with colchicine therapy.

Case Report

A 35-year-old married male of Italian ancestry was admitted to the hospital with acute abdominal pain in the lower right quadrant accompanied by a fever of 102° F and an elevated white blood cell count. After two days the fever abated and the abdominal pain subsided. A gastrointestinal x-ray series, barium enema x-ray, cholecystogram, and intravenous pyelogram were negative. The patient was discharged from the hospital only to return two weeks later with the same

symptoms. He was then put on a liquid diet, aspirin, and bed rest until the fever subsided. Two days later all symptoms diminished, but they returned within three weeks.

At this time, the fever was 104° F with chills, severe abdominal pain, distension of the abdomen and an elevated white blood cell count. Oxytetracycline was prescribed in dosage of 250 mgs four times a day for four months. The patient remained asymptomatic, however the cycle of attacks recurred, despite the oxytetracycline treatment so the antibiotic therapy was discontinued. The same x-rays were repeated and remained negative.

The patient was then referred to the Lahey Clinic in Boston, where a diagnosis of familial Mediterranean fever was entered on the patient's record in November 1973.* This diagnosis was based on the fact that the attacks were cyclic, that the patient's father was born in the Mediterranean area, and that other conditions such as diverticulitis, colitis, gallbladder disease, and so on were ruled out. Since there was neither a known cause nor effective treatment for FMF at that time, the patient was told he would "have to live with the condition."

In June 1974, review of Goldfinger's treatment of FMF with colchicine and consulting with him, we began treatment of the patient with colchicine in dosage of 0.6 mgs. b.i.d. During ten months of colchicine treatment, for which twenty attacks were anticipated, none occurred. There were no adverse side effects of colchicine other than occasional mild diarrhea.

Discussion and Conclusion

Doctor Goldfinger admits that the mode of colchicine suppression of attacks of FMF is not clear, but he speculates that it may be due to a primary action of the drug causing microtubular disaggregation. Whatever the action, he is convinced of colchicine's therapeutic value in FMF.

It is concluded that colchicine, when given continually in low dosage, is extremely effective in suppressing attacks of FMF. A therapeutic trial of colchicine is recommended for selected patients with unexplained recurrent attacks of abdominal pain and fever.¹⁶

*Personal communication from Francis E. McDonough, M.D.

Roosevelt Hospital

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Disseminated histoplasmosis resembling miliary tuberculosis is reported from a geographic area in which tuberculosis of all types is common but histoplasmosis unusual. The source of the infection is uncertain; although the patient traveled through areas in which histoplasmosis is endemic, he also self-injected narcotics of unknown purity. Initial suspicion of the correct diagnosis arose from bone-marrow examination. Serum electrophoresis pattern showed a transient monoclonal spike which, by immunodiffusion, proved to be IgM. This has recently been suggested as characteristic of the acute phase, as opposed to the chronic phase of histoplasmosis where IgG alone predominates. Treatment included amphotericin B together with antituberculosis drugs. Our patient left the hospital apparently cured before receiving one third of the recommended dose of amphotericin B, raising the possibility that concomitant rifampin medication might have acted synergistically.

Transient Plasma Cell Dyscrasia in Disseminated Histoplasmosis

**V. V. Daly, M.D., R. F. Damania, M.D.,
C. H. Hung, M.D., S. Trubowitz, M.D.,
and L. F. Ayvazian, M.D./East
Orange***

Recent studies of antibody response in experimental and human histoplasmosis suggest correlations between specific immune globulins M and G (IgM, IgG) activity and the phase of disease.^{1,2} IgG predominates in human serum throughout the illness, while transient IgM elevation may characterize primary or disseminated infection.

The following report describes a patient with disseminated histoplasmosis in whom the early antibody response was predominantly in the form of IgM and appeared as a monoclonal spike. Other considerations included the unusual occurrence of acute miliary histoplasmosis in Newark, New Jersey; the speculative source of the patient's infection; and apparent cure under therapy with substandard amphotericin B dosage but with concomitant rifampin.

Case Report

A 35-year old man was seen at the admissions office of the East Orange, New Jersey, Veterans Administration Hospital on three occasions on successive weeks prior to his admission on November 6, 1973. His complaints of malaise, cough, and fever did not differ from those of other patients seen during the influenza season, and his chest roentgenogram was considered unremarkable. Hospital admission resulted because of increase in severity of his symptoms and the appearance of punctate, fine densities evenly distributed throughout both

lungs and radiologically suggesting miliary tuberculosis (figure 1).



Figure 1 — Initial chest roentgenogram showing bilateral diffuse miliary infiltration (Nov. 7, 1973).

*This work is from the Pulmonary Disease and Hematology Sections of the Veterans Administration Hospital, East Orange, where Dr. Daly is Staff Physician, Dr. Damania is Resident in Medicine, and Dr. Ayvazian is Chief of the Pulmonary Disease Section; Dr. Hung is Resident in Medicine and Dr. Trubowitz is Chief of the Hematology Section. Drs. Trubowitz and Ayvazian are Professors of Medicine, New Jersey Medical School, CMDNJ, Newark. Reprints requests to Dr. Daly.

From his family, it was learned that the patient was a native of Newark and an interstate truck driver whose route spanned New York and Illinois. He used narcotics, often intravenously and under unsanitary conditions. The patient's mother had been treated with isoniazid for pleurisy 10 years earlier.

The patient was tachypneic and febrile (102°F). Rhonchi and rales were audible over all areas of both lungs. Scars were apparent along the veins of his arms. Circulating white cells totaled 5,900 per mm³ and hematocrit was 29 percent. Proteinuria was present. Sputum specimens were collected and tetracycline therapy was initiated for a possible bacterial infection complicating influenza.

During the ensuing 48 hours, the patient's fever continued to rise and he became stuporous. Additional material was taken for study: blood, urine, bone marrow, and (by needle biopsy) liver. On the third hospital day, therapy for possible miliary tuberculosis was begun with streptomycin (1 gm. intramuscularly daily), isoniazid (300 mg daily), and rifampin (600 mg daily). Because of alarming clinical deterioration, prednisone medication was added. On the fourth hospital day, amphotericin B medication was added because of bone-marrow findings suggesting *H. capsulatum* infection. Radiologically, increase in the disseminated pulmonary disease was apparent. Blood platelets fell to 25,000 per mm³ (normal: 200,00 per mm³) and hematocrit to 20 percent. Sputum examination failed to reveal predominant bacteria, common pathogens, or tubercle bacilli. Skin reactivity to 5 units of PPD-S was absent at 48 and 72 hours. Smears from bone-marrow aspirates showed ovoid bodies in the cytoplasm of the reticular macrophages.

A second bone-marrow aspirate revealed hypercellularity with a moderate increase in the myeloid compartment, plasmacytosis (figure 2), and mild megaloblastosis. Again, oval-shaped organisms surrounded by halos were visible in the cytoplasm of the reticular macrophages (figure 3). From this aspirate *H. capsulatum* was cultured; mycelia grew on Sabaroud's medium at 25°C (figure 4) and yeast forms at 37°C (figure 5). Subsequently, typical tuberculate chlamydispores were obtained on subculture (figure 6). Ex-

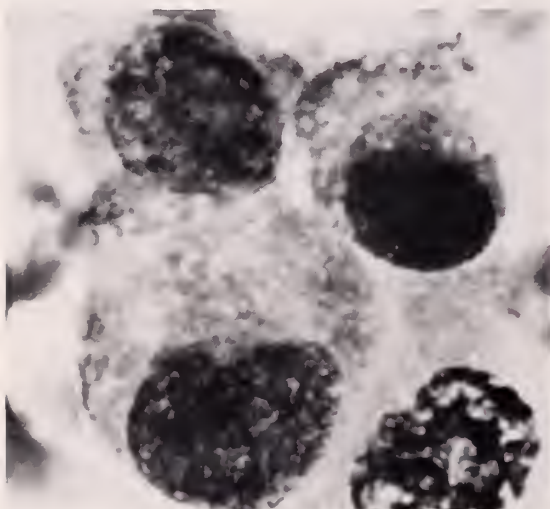


Figure 2 — Cluster of plasma cells in bone marrow. (May Grunwald-Giemsa Stain. Ca — 1500 Diameters.)



Figure 3 — Reticular macrophage in bone marrow. (May Grunwald-Giemsa Stain. Ca — 1500 Diameters.) Note oval-shaped intracellular organisms with halo, typical of *H. capsulatum*.



Figure 4 — Mycelia from bone marrow culture on Sabaroud's medium at 25°C. (Interference microscopy. Unstained. Ca — 1500 Diameters.)



Figure 5 — Yeast forms in bone marrow culture on Sabaroud's medium at 37°C. (Interference microscopy. Unstained. Ca — 1500 Diameters.)



Figure 6 — Tuberculate chlamydospores from bone-marrow subculture (Interference Microscopy.)

amination of the liver-biopsy specimen showed granulomatous lesions in which were seen intracellular bodies highly suggestive of *H. capsulatum*.

Amphotericin B was injected intravenously at an initial dose of 1 mg, and this was followed by increments of 5 mg every other day until 60 mg (1 mg per kg per day) was received. Within 24 hours of amphotericin B therapy the patient became alert and his fever subsided; however, because of azotemia, the maintenance dose of amphotericin B was adjusted at 40 mg every 2 to 4 days.

For the remainder of his 6-week hospital stay his improvement was uninterrupted. He gained 12 pounds and became free of symptoms. Blood leukocyte counts remained normal and his platelets rose to 126,000 per mm³. Prednisone dosage was slowly decreased but antituberculosis drugs continued,



Figure 7 — Chest roentgenogram 9 months after therapy (August, 1974), showing clearing of miliary infiltration and residual scattered nodulation.

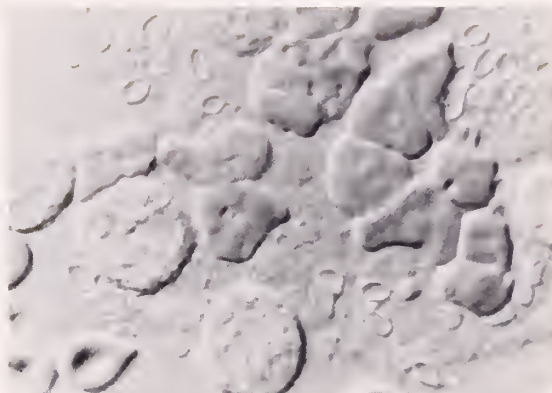


Figure 8 — Bone marrow aspirate during recovery showing empty ovoid forms in cytoplasm of reticular macrophages. (Unstained. Interference Microscopy. Ca — 1500 Diameters.)

since proof of fungal infection was not established until late in his hospital stay. Amphotericin B dosage was maintained at 40 mg every other day, until the patient left against advice on December 15, 1973. The sum of amphotericin B actually received was 635 mg, far short of the 2,000 mg planned by calculation according to body weight. The patient refused to return, possibly having resumed his use of narcotics, but on August 12, 1974, 10 months after the initial evidence of his infection, he was readmitted to another ward in the hospital with minor and irrelevant complaints. He showed no evidence of infection, and his chest roentgenogram (figure 7) was clear of disseminated disease; a few scattered nodules had appeared. During recovery, bone marrow aspirate showed empty ovoid forms in macrophage cytoplasm (figure 8).

Studies, when completed, showed the following: *H. capsulatum* was cultured from a bonemarrow aspirate of November 12, and from three sputum specimens collected on November 7, 9 and 20, 1973. No fungus grew from urine, blood or liver tissue. All of these specimens failed to yield tubercle bacilli. Electrophoresis of serum on the third hospital day, when the patient's illness was most severe, showed a striking monoclonal spike which, by quantitative radio-immunodiffusion proved to be IgM (figure 9, table 1). Within three weeks, this IgM activity subsided, coinciding with clinical improvement. Table 2 lists the results of three serum electrophoretic studies and shows serial falls in alpha 1, 2, and gamma globulins, and rises in beta globulins and

SERUM IMMUNOGLOBULIN ELECTROPHORESIS

11/9/73	1	1
11/25/73	1	

Figure 9 — Serum immunoglobulin electrophoresis showing monoclonal IgM spike on Nov. 13, 1973 but not on Nov. 29, 1973.

albumin. Serologic tests for *H. capsulatum* antigens (GW Yeast, VC Yeast, and Histoplasmin) were negative at the time of the patient's admission and prior to his discharge but positive midway in his hospital stay (table 2).

Table 1

Serum Radial Immunodiffusion

Date	IgA	IgG	IgM	C'3
11/13/73	174 mg%	1650 mg%	2135 mg%	27 mg%
11/29/73	164 mg%	1830 mg%	440 mg%	46 mg%

Table 2

Serum Protein Electrophoresis

Date	Albumin	Alpha 1	Alpha 2	Beta	Gamma
11/9/73	29.8%	4.0%	8.6%	5.6%	52.0%
11/21/73	43.3%	4.1%	7.0%	8.5%	36.7%
11/29/73	44.9%	2.8%	6.9%	11.2%	34.2%

Table 3

*Serologic Tests For Histoplasma Capsulatum Antigens**

Date	GW Yeast	VC Yeast	Histoplasmin
11/9/73	Negative	Negative	Negative
11/23/73	1:64	1:128	1:256+
12/11/73	Negative	Negative	Negative

*Performed by the Special Serology Reference Laboratory, Veterans Administration Hospital, Lexington, Kentucky.

Discussion

Acute disseminated histoplasmosis is characterized by gradual debility with unremitting progression associated with involvement of liver, spleen, bone marrow, and other organs as well as lungs.¹ Ninety-five percent of untreated patients die but only 10 percent succumb when adequately treated with amphotericin B.^{3, 4, 5} "Adequate" treatment generally refers to use of amphotericin B for periods of 16 to 22 weeks at a total dosage of 25-38 mg per kilo bodyweight; higher amounts are advocated for the more virulent infections.^{4, 5} Computed at a mid-point of 31 mg per kilo of this patient's bodyweight, amphotericin B totals 2,000 mg, but he actually received 635 mg, less than a third of the recommended "curative" sum for this fulminant type of infection. Nevertheless, his recovery from stupor was prompt and sustained.

Synergistic fungicidal action of rifampin and "subtherapeutic" concentrations of amphotericin B have been reported in *in vitro* studies and experimental infections with *H. cap-*

sulatum.^{6, 7, 8} A patient with thoracic cold abscess due to *H. duboisii* was successfully treated with rifampin alone.⁹ Our patient received 2 antituberculosis drugs in addition to rifampin throughout the hospital stay, but there is no reason to believe that isoniazid or streptomycin contributed to his recovery. Amphotericin B was added to his therapy within 24 hours of the other three drugs, the differential diagnosis between tuberculosis and histoplasmosis being uncertain. Improvement, thereafter, was prompt and beyond expectation and so rapid that the patient could not be persuaded of the prognostic potential of his illness, nor dissuaded from leaving the hospital before therapy could be completed as planned.

On the 7th day of therapy, when the patient had received just 195 mg of amphotericin B, a reduction in dosage (from 60 mg od to 40 mg od) was required because of evidence of renal damage. The possibility that histoplasmosis might successfully be treated with subtoxic amounts of amphotericin B together with rifampin deserves consideration. Also noted in our case was a monoclonal serum IgM spike with an associated plasmacytosis. Quantitative immunodiffusion measured a sixfold increase in IgM (table 1), but within three weeks the electrophoretic pattern returned to normal. Bone-marrow aspirate, which showed considerable increase in plasma cells (10 to 12 percent) initially, suggested a reactive process rather than neoplasm.

Among others, Baum¹ has demonstrated the presence of IgM and IgG specific complement-fixing antibodies in acute histoplasmosis, IgG activity alone being characteristic of chronicity. The relationship between immune-globulin titers and disease prognosis has not been established. The early production of IgM antibody is shared by other acute infections including those caused by Rickettsiae, Listeria, toxoplasma, and malaria.¹⁰⁻¹⁴ IgG, predominant in chronic histoplasmosis, is also predominant in recrudescent typhus and chronic brucellosis.^{13, 15, 16} Benign plasma-cell dyscrasia has been described in a variety of inflammatory states as well as transient plasma-cell dyscrasias in some acute infections.¹⁷ Immunoglobulin alterations have also been associated with heroin addiction, but the importance of infection in this group is not

clear.¹⁸ Histoplasmosis may possibly be added to the list of conditions capable of provoking transient plasma-cell dyscrasia.

It is speculative whether the patient here discussed acquired systemically disseminated histoplasmosis because of highway truck-driving through mid-eastern states or from contamination of self-injected narcotics. The latter possibility merits consideration in communities in which both drug-use and tuberculosis (the initial diagnosis in this instance) are common.

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Primary care can be provided in a variety of ways by a variety of people, funded by distinct methods. Little evidence is available to conclude which of these is best; there is much to suggest that local factors will heavily influence such conclusions. It is essential that we continue to test many models and recognize that our society, composed of dissimilar constituencies, may require heterogeneous solutions.

Primary Care — A Pluralistic Approach

Richard H. Rapkin, M.D., Green Brook*

The provision of primary care, the services which were traditionally provided by the general practitioner, is the subject of a major controversy in medicine today.¹⁻³ Who should provide it, and how shall the providers be trained? How shall the care be organized and funded? These are questions that have been discussed unendingly. Unfortunately, the discussion has generated much heat but not as much light.

An old adage, paraphrased, states that when there are multiple solutions for a problem repeatedly proposed by reasonable people, it is likely that no one solution is ideal. Our society is uniquely pluralistic in its makeup, and one of our great strengths has been our heterogeneity. It may be, that a variety of innovative programs, developing simultaneously, will reveal that there are many good ways to provide primary care or that one particular method is ideal. The thesis to be developed in this discussion is that it is essential for us to proceed along several paths unless or until it becomes patently obvious that one path is best.

The Provider

Who should provide primary care and how shall such individuals be trained? Three major controversies have evolved: 1. The team versus the individual; 2. The family practitioner versus the pediatrician-internist; 3. The physician versus the non-physician health practitioner. These controversial subjects are not mutually exclusive; significant overlap exists.

What is the place of the generalist, the primary care doctor who can do it all, but is aware of his limitations and is willing, and anxious, to refer problems beyond his capacity?⁴ The proponents of this provider of primary care argue, with much logic, that a well-trained primary physician can provide continuity (and all that that im-

plies^{5,6}) and comprehensiveness in one easily accessible place. The opponents note that no one provider can be expert enough to address the medical, social, psychological, and educational aspects that they consider essential to primary care. They argue that the physician is only one member (albeit the leader) of a team of providers. They agree that a danger of loss of continuity exists but they are willing to accept that risk, as opposed to the perceived gain in the quality of care by the team approach.

The main issue is quality. How can one person, it is argued, no matter how well trained, be the provider of all the complexities of primary care? The answer might be that when "complexities" are identified, the family practitioner will seek the additional expertise needed. The retort is that the physician practicing alone may not even perceive these problems.

It is obvious that, without careful studies, which may be very difficult to do, there may be no end to this disagreement. Is it not wisest, therefore, to develop, as is being done, both concepts? It may be that these are not equally applicable types of care.^{7,8} How will a rural community be able to support a health team? How can a solo practitioner hope to provide adequate care to urban poor?

Should the "medical" aspects of primary care be provided by the physician only, or are "physician extenders" or other health care professionals (nurse practitioners, physician assistants) better, or equal, and cheaper?⁹⁻¹¹ That nurse practitioners can provide quality primary care to many patients has been well documented.^{12,13} There is no doubt that treatment by such prac-

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tioners is limited to well-defined facets of clinical medicine such as health maintenance and management of minor illness, under the supervision of a physician. Some feel that these professionals can be more comprehensive in their handling of these problems than their physician counterparts because the latter are more likely to be less interested in the "mundane" aspects of care or too busy with more serious problems. Cost of medical care (see below) may be reduced by utilization of practitioners whose educational training is shorter than a physician's.¹⁴ As a corollary, the availability of the more sophisticated evaluation that the physician can provide may be increased by reducing his load of simpler problems.

An underlying issue here appears to be the fear of the development of independent limited care practitioners, or a reduction in quality of care by the use of not-completely-trained personnel.¹⁵⁻¹⁷ This danger exists and may only be answerable by careful review of activities of all practitioners (M.D. or other) by qualified observers.

What is the best way to train a primary care physician?¹⁸⁻²² Should he be enrolled in a family practice residency or is he better trained by spending time in both a pediatric and internal medicine residency? Most observers agree that there are advantages and disadvantages to each. A family practice residency provides opportunity for comprehensive and continuous care for a defined group of patients (the model practice unit) which does not usually exist in pediatric or internal medicine programs. The latter, however, allows exposure to "state of the art" care in each specialty so that the trainee learns how to use referral services and to know his own limitations. In a family practice residency, one's teachers are largely the primary care practitioners of the past, whose knowledge of current medical practice may be limited. In pediatric and internal medicine residencies there is often very small emphasis on prevention, counseling, and other such aspects of the management of common illness.

It is likely that new models of training will be developed so that the strengths of each type of program are incorporated. This whole area demonstrates emphatically the need for innova-

tion and a variety of approaches toward the same goals. It is obvious that family practice residencies could use rotations through pediatric and internal medicine services, where there are specialist training programs, to enhance the background of the family practice trainee. In addition, pediatric and internal medicine programs could join with each other to develop a "practice track," to which could be added a panel of patients to be followed over a period of years as in the model practice unit of family practice.

The training of allied health care providers poses other problems. Pediatric Nurse Practitioners (PNP), striving for their own identity, are feeling increasingly confident in their ability to train each other, rather than depend upon pediatricians. Their arguments are that nursing is a profession which should be led by nurses and that being a nurse practitioner is a logical extension of nursing. The pediatrician, on the other hand, sees the PNP in some of the traditional roles of the physician and, believes she must be trained for this role by the physician. If we exclude an argument which often confuses the issue — that of professional turf — there is no logical reason to avoid proceeding along both lines. Nurse practitioner training should be evaluated by assessing the attainment of educational objectives. This will answer the question, which will not be answered by prolonged argument, without data, over which is better.

The Organization

The organization of primary care depends upon the answers to many of the above questions,^{23,24} and, therefore, strict conclusions cannot be drawn. In order to evaluate various delivery models, however, some of them should interact directly with each other so that the practical advantages and disadvantages of each can be assessed. Instead of just providing different models in different areas, and then being unable to compare them because of underlying geographic, socio-economic, or cultural differences, it might be wiser to allow several models to function together under one roof. It promptly may become obvious which model is most effective and efficient under given local conditions.

In the same way, the funding may be evaluated.

There has been a fair amount of philosophic discussion of the funding of medical care, most of which depends upon the basic beliefs of the discussant: capitalistic or socialistic.²⁵⁻²⁸ These are not necessarily mutually exclusive. Our society is learning that not all things are solved by free enterprise nor by bureaucratic governmental planning. We need to evaluate carefully fee-for-service, prepaid care, private insurance, and governmental plans to determine which are most desirable. At present there is so much defense of the status quo that it is impossible to resolve this by argument. Again, data are needed and may be provided by allowing a variety of plans to function together in a location where quality of care, socio-economic, and other factors can be controlled and the variables of funding can be tested.

Conclusion

It is not being suggested that all of these things can be assessed simultaneously and at the same location. It is vital, though, that we keep our options open and attempt, with as little bias as possible, to evaluate a variety of primary care methodologies, controlling as many of the variables of life as possible. It is also essential to keep open the possibility that there is no one best way, and that in our uniquely heterogeneous society there may be the requirement of heterogeneous services. We must support each other's innovations without preliminary condemnation, if we are to find our future health.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 20, 1975

A regular meeting of the Board of Trustees was held on July 20, 1975, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Guests at Board Meetings . . . Established the policy of including the presidents of specialty societies among the invited guests at meetings of the Board of Trustees.

HEW Ruling Concerning Medicare and Medicaid Regulations (Resolution #14) . . . Directed that no action on Resolution #14 (non-compliance with HEW ruling) be taken until such time as the litigation between the AMA and HEW is final. As of July 18 the granting of the preliminary injunction in the implementation of the HEW ruling concerning Medicare and Medicaid admissions had been appealed to the Circuit Court of Appeals; a final decision had not been reached. The Government's motion to lift the injunction had been denied. The Executive Director is of the opinion that should non-compliance be urged and the HEW regulation adopted, an economic catastrophe would result in most hospitals.

Proposed Regulation on Hospital Reporting in Relation to 1977 Rate Setting . . . Voted to recommend to the Department of Health that all regulations concerning hospital reporting in relation to the 1977 rate setting system be held in abeyance and that a pilot project be established in voluntary cooperative hospitals. A final opinion could be rendered following the receipt of the results of the pilot project.

. . . Directed that the Commissioner of Health be informed of the action taken.

Proposed Revision of Guidelines and Criteria for Submission of Certificate of Need Applications . . . Directed that the above-named revisions be referred to the Executive Director

for development of comments to be submitted to the Department of Health.

Hospital Application Forms for Present and New Staff Members (Resolution #28) . . . Directed that MSNJ, bound by Resolution #28, transmit notice of opposition to the above-mentioned form to the Joint Commission on Accreditation of Hospitals, the New Jersey Hospital Association, and process an appropriate resolution at the AMA Clinical Session (1975).

Note: Joint Commission on Accreditation of Hospitals has advised that there is no requirement that the form be mandated in approved hospitals; it is merely advisory. Defense counsel indicates that the form may be a nuisance and irritant to physicians but it in no way increases or affects professional liability exposure or violates legal or civil rights.

Medicaid — Proposed Revision Concerning Generic Dispensing . . . Directed that a request be made for a public hearing prior to the promulgation of a proposed Medicaid regulation that reimbursement for multi-source legend drugs shall be limited to generic prices regardless of the brand actually prescribed or dispensed.

Medicaid — Proposed Temporary Fee Reduction . . . Voted to adopt as the official MSNJ position a statement by John W. Alexander, M.D., outlining the reasons for opposition to the proposal of the Department of Institutions and Agencies to reduce, by ten percent, the fee for all professional services rendered under Medicaid, effective September 1, 1975; the reduction is "expected to be eliminated" on July 1, 1976.

Public Hearing on Chubb Rate Filing . . . Voted not to present a formal statement at the public hearing on the Chubb Rate Filing, but to have MSNJ representatives (President McGuire and Executive Assistant, Mr. Lucci) available to answer questions.

Physician Advertising . . . Noted that, concerning physicians' advertising in the program for the Twelfth Annual Convention of the American

Association of Medical Assistants, the Judicial Council rendered an opinion that in the sponsorship of such projects only the physicians' names be listed and that the guidelines on advertising (NJSA 45:9-16 (j)) be strictly adhered to; notice of this opinion has been forwarded to the physicians listed in the program.

Professional Liability:

Legislation Regarding Malpractice Insurance (Resolution #10)

Statute of Limitations (Resolution #12)

Malpractice Law Revision (Resolution #24)

Malpractice Legislation (Resolution #33)

. . . Approved the following recommendation from the Council on Legislation:

That in compliance with the directive of the House, the Board of Trustees approve the appointment of a "Joint Ad Hoc Committee on Professional Liability" consisting of the Chairman and Vice-Chairman of the Council on Legislation, the Chairman and Vice-Chairman of the Standing Committee on Medical Defense and Insurance, two members-at-large, to be selected by the President from each of these respective groups, and that the President, the Chairman of the Board, or another Trustee chair the committee.

Chairman of the Board, James S. Todd, M.D., was appointed chairman of the above-named committee, and upon request of the New Jersey State Society of Anesthesiologists, Harvey Hatchfield, M.D., will be invited to attend committee meetings as a representative of the Anesthesiology Society.

Proposed Legislation Concerning Professional Liability:

Informed Consent . . . Approved as amended the following proposed legislation regarding informed consent:

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

Section 1. In a civil action based on alleged professional negligence of a person licensed under N.J.S.A. 45:9-1 et seq. there shall not be submitted to the jury or the court the issue of whether or not the plaintiff who suffered the personal injury gave an informed consent to the procedure out of which such personal injury arose, unless the plaintiff shall have proved, by affirmative evidence, that the defendant did not supply appropriate information to the plaintiff in obtaining his informed consent in accordance with the recognized standard of acceptable professional practice in the profession and in the specialty thereof, if any, and in the community in which he practices or in a similar community.

Section 2. Evidence concerning informed consent shall be based upon the testimony of an expert witness, licensed to practice the same profession as the defendant.

(Italics indicate amendment by the Board of Trustees.)

A Bill to Establish the Professional Liability of Health Care Practitioners . . . Approved the following proposed legislation to establish the professional liability of health care practitioners:

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1) No health care practitioner licensed, certified, or registered pursuant to the Revised Statutes of New Jersey shall be held liable for damages in tort attributable to an injury or wrong alleged to have occurred to any person during treatment or non-treatment in excess of \$500,000.00 (five hundred thousand dollars) for a claim of professional liability.

2) This limitation does not apply when the act committed was criminal in nature, gross negligence, or willful and wanton misconduct.

3) This act shall take effect immediately.

State Legislation . . . Approved as amended the following positions on bills of medical import recommended by the Council on Legislation:

S-3155 — To permit health insurance coverage (other than group and blanket) for outpatient treatment of the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-3156 — To permit group and blanket health insurance coverage for outpatient treatment for the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-3157 — To permit hospital service corporations to make available coverage for outpatient treatment of the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-3158 — To provide various amendments to the act concerning the manner of disposition of cases of child abuse or neglect. *NO ACTION*

S-3177 — To require boards of education to identify and provide special programs for hearing-impaired children under the age of 5 and for handicapped children, classified pursuant to Article 4 of Chapter 46 of Title 18A, ages 5 through 20 years. *NO ACTION*

Note: Council's recommendation of "approved" was amended by the Board to "no action."

- S-3191* — To provide that a court shall fix the fee for examinations by physicians where testimony is required in an action for injuries or where the mental or physical condition of a party is in controversy. *APPROVED*
- S-3200* — To provide that when an abortion is to be performed after the 20th week of pregnancy, a physician other than the physician performing the abortion shall be in attendance to provide immediate medical care for any live child the result of the abortion, and to authorize the Commissioner of Health to promulgate rules and regulations. *DISAPPROVED*, because the Department of Health already has authorization to promulgate such rules and regulations.
- S-3201* — To provide for the establishment of a Graduate Medical-Dental Education Program to be selected by a newly created Graduate Medical-Dental Education Board and to appropriate \$300,000. *APPROVED*
- S-3223* — To provide for investigation into the deaths and examination of infants under 3 years of age where the suspected cause is sudden infant death syndrome. *APPROVED*
- S-3224* — To prescribe as a misdemeanor the performance of abortions by any method, involving the intrauterine injection of a hypertonic solution, except where the physician adjudges another method imposes an unreasonable danger to the life of the woman. *ACTIVE OPPOSITION*, because this bill legislates the practice of medicine without proper knowledge of the procedure involved and also because there is no evidence that this procedure, when properly administered, is any more dangerous than any other abortion procedure.
- S-3232* — To create a joint underwriting association to provide medical malpractice insurance on a self-supporting basis without subsidy from its members or their policyholders. *ACTION DEFERRED*, referred to Joint Ad Hoc Committee on Professional Liability.
- S-3239* — To permit minors, who are or profess to be afflicted with a venereal disease, to consent to medical procedures where the minor appears to have been sexually assaulted. *APPROVED*
- S-3246* — To establish a State catastrophic health insurance plan, to provide for the certification of health benefits' plans as qualified and for the regulation of insurers and providers of health care services and to establish a health resource development fund. *ACTION DEFERRED*, pending further study of the bill by MSNJ and the New Jersey Hospital Association.
- S-3264* — To require physicians to report to the county prosecutor cases of suspected child abuse. *CONDITIONAL APPROVAL*, pending the following revision: That the physician report the incident either to the Bureau of Children's Services, the local police department, or the county prosecutor.
- S-3268* — To define "dwelling" in the law prohibiting the use of lead paint to include day care centers and nursery schools. *APPROVED*
- S-3285* — To provide that the majority of membership on professional boards and commissions shall be public members and that meetings of such shall be open to the public. *ACTIVE SUPPORT*, pending the following amendment: That all professions and occupations are included within the bill.
- Note:* Council's recommendation of "conditional approval" with the same stipulation was amended by the Board to "active support."
- A-3264* — To permit ophthalmic dispensers and technicians to advertise. *NO ACTION*
- A-3304* — To require the Director of Motor Vehicles to provide a procedure for noting upon a driver's license that the licensee is a donor under the Uniform Anatomical Gift Act. *APPROVED*
- A-3305* — To permit deposits of documents showing the nature of a gift under the Uniform Anatomical Gift Act with the Director of Motor Vehicles. *APPROVED*
- A-3319* — To provide medical and health services to persons not eligible for any of the categorical assistance programs. *CONDITIONAL APPROVAL*, pending the following amendment: Provided that adequate supplemental funds are available.
- A-3322* — To authorize the Higher Education Assistance Authority to adjust maximum guaranteed loan limits for graduate and professional students. *APPROVED*
- A-3347* — To require all group medical service contracts to provide benefits of at least \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*, pending further information from Medical-Surgical Plan of New Jersey.
- A-3348* — To require all group health insurance policies to provide benefits at least equal in value to 60 days' hospitalization and \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*, pending further information from the Health Insurance Council.
- A-3349* — To require all group hospital service contracts to provide benefits at least equal in value to 60 days' hospitalization as a result of mental illness. *ACTION DEFERRED*, pending further information from Hospital Service Plan of New Jersey.
- A-3375* — To provide for unannounced inspections of nursing homes by the Department of Health at least twice a year. *NO ACTION*
- A-3442* — To delete the prohibition against advertising the prices of prescription drugs in the act concerning the professional conduct and practice of phar-

macists. *DISAPPROVED* because, although MSNJ approves of the concept of listing prices for pharmaceutical products, this Society believes that permitting commercial advertising approaches in mass media and elsewhere would place smaller pharmacies at a distinct disadvantage to large chain operations.

Note: Council's recommendation of "no action" was amended by the Board to "disapproved" for the reasons cited.

A-3488 — To combine amendments contained in health insurance law contained in Assembly 1503 and Assembly 22. *NO ACTION*

A-3499 — To permit minors to consent to medical procedures when in the judgment of a physician the minor appears to have been sexually assaulted. *APPROVED*

A-3531 — To permit first aid or rescue squads to display special identification lights on motor vehicles and to require the Director of Motor Vehicles to prepare suitable identification cards to be countersigned and issued by the chief executive of any municipality which must be carried by persons while emergency lights are displayed on a vehicle. *APPROVED*

Bills Noted and Filed:

S-3255 — To prohibit the importation or sale of any dog under the age of 10 weeks unless it has been certified by a licensed veterinarian of the state from which imported that it has been inoculated.

SCR-3027 — To request the Commissioner of Institutions and Agencies to continue full payment of pharmaceutical assistance and other medical and health benefits provided for in the Medical Assistance and Health Services Act.

SR-3008 — To create an 11 member committee to investigate abortion clinics and to rescind SR-3002 adopted April 7, 1975.

SR-3014 — To provide that it shall be the duty of the Abortion Clinic Study Commission to investigate the operation of abortion facilities and procedures to determine to what extent they serve the needs, health and welfare of the citizens.

A-3446 — To provide that a court may award the State all costs of investigation and trial including attorneys' fees for actions brought under the Legislative Activities Disclosure Act.

A-3447 — To provide that any person who employs an unregistered person as a legislative agent shall be guilty of a misdemeanor.

A-3448 — To provide that any legislative agent who causes or secures the introduction of any legislation for the purpose of being employed to prevent the passage thereof shall be guilty of a misdemeanor.

A-3449 — To provide that any legislative agent who represents an interest adverse to his employer's without obtaining written consent after full disclosure shall be guilty of a misdemeanor.

A-3450 — To provide that no person shall employ a legislative agent for compensation contingent upon the success of any attempt to influence legislation.

AJR-3011 — To support the establishment, development and operation of the South Jersey Medical Complex and location of a Veterans Administration Hospital in center city Camden. Law, c.Jr-3 ('75)

Annual Meeting . . . Approved the following recommendations from the Committee on Annual Meeting:

1. That the annual meetings of MSNJ continue to be held in New Jersey.

2. That the 210th Annual Meeting of MSNJ be held Friday, June 4 to Tuesday, June 8, 1976, and that the Cherry Hill Hyatt House be designated as the headquarters hotel.

3. That the AMA Issues Workshop (Resolution #1, 1975 House of Delegates) be implemented and the workshop be scheduled for Sunday, June 6, 1976, preceded by breakfast at 7:30 a.m.; that notice of intention to hold the workshop be sent to the membership in March 1976; and that the AMA Issues Workshop be adopted for future years, not merely for a one-year trial period.

4. That a proposal from Donald B. Louria, M.D., that a session at the 1976 Annual Meeting be devoted to primary and secondary prevention in adult medicine be accepted and that it be the subject of the second annual Governor's Conference.

5. That the policy of reserved tables for the 1976 Dinner-Dance be re-established; that there be scheduled a dinner with dancing and entertainment on Saturday evening; and that, if the inaugural dinner is not open to the membership, a dinner and entertainment be planned for that evening, for those not attending the inaugural dinner.

6. That the honoraria for guest speakers remain at \$150 for 1976.

7. That the Medical Assistants Association again be invited to sponsor the message center in 1976.

8. That the Golden Merit Awards be separated from the Sunday session of the House of Delegates, that the ceremony be a private session to be held at 12 noon on Saturday of the Annual Meeting, and that the membership be invited.

Annual Meeting Committee Chairman . . . Noted that President McGuire had appointed James E. D. Gardam, M.D., chairman of the Committee on Annual Meeting, to succeed Arthur Bernstein, M.D., who had been elected Secretary of the Society and in that capacity is an ex-officio member of the Committee.

Woman's Auxiliary . . . Approved the proposed program for 1975-1976 for the Woman's Auxiliary which is identical to that of last year.

New Jersey Hospital Association . . . Received a report from John S. Madara, M.D., MSNJ's liaison representative to the New Jersey Hospital Association Board of Trustees of the June 12 and July 9 meetings, which included the following highlights:

1. There was a long discussion of the advisability of reinsuring hospital employees with an insurance company other than Blue Cross.

2. A motion was passed to appoint a committee to consider the Chicago Hospital Council's Rape Treatment Guidelines for amendment and adoption by NJHA, and to include in its consideration alcohol and drug abuse.

3. A report was given on recent actions taken at our annual meeting in Cherry Hill.

4. There was a discussion of professional liability legislation and the recent problem of anesthesiologists' coverage.

5. There was a report by Kenneth Williamson, Washington analyst, of recent happenings in Washington. Among his opinions were:

(a) In the replacement of Casper Weinberger as Secretary of Health, Education, and Welfare by Dr. Matthews, who knows more about education than health or welfare Dr. Cooper will probably be the power in the health field

(b) The generic drug bills at present in Congress will attempt to widen the gap between hospitals and physicians

(c) Congress will try to curtail foreign medical graduates, including those American students who go out of the United States for their medical education

(d) Judge Hoffman's temporary injunction concerning recertification of admissions will not be upheld.

6. The principle of offering Prudential coverage in lieu of Blue Cross for an Employee's Health Plan was endorsed.

7. It was recommended "that maternity benefits in the Blue Cross contract be expanded so that complications in pregnancy will no longer be charged against the patient's available maternity benefits."

8. It was recommended "to approve the elimination of blood replacement as a requirement for Blue Cross blood processing cost eligibility."

9. A questionnaire relating to the present utilization and purchase of axial tomography services for patients will be sent to member hospitals.

10. It was recommended "that payment of all costs associated with PSRO-mandated regulations, be funded through Federal mechanisms."

American Hospital Association . . . Received as informative the following report from John S.

Madara, M.D., Regional Delegate to the American Hospital Association, on the July 15th Region II Advisory Board meeting, when the following actions were taken:

1. Voted to support the concept of institutional licensure as well as state licensure of individual health care workers.

2. Suggested the following changes in the *Guidelines on Contractual Relationships between Hospitals and Physicians*:

(a) To make it permissive, rather than mandatory, that the governing authority of a hospital seek advice of appropriate medical staff representatives in approving the schedule of charges for the services provided.

(b) To delete the provision that physicians' contracts be reviewed by appropriate medical staff representatives, and have only the contracting physician, administrator and governing board involved.

(c) To add *Fee for Service* as the sixth alternative for Physician's Compensation for professional services; the other five being (1) Salary, (2) Percentage of Net Departmental Income, (3) Percentage of Net Departmental Income with Sliding Scale, (4) Percentage of Adjusted Gross Departmental Billings, (5) Percentage of Adjusted Gross with Maximum Limit.

(d) To delete the statement that "the hospital, and the physician as well, will find the salary arrangement the least cumbersome of the alternative arrangements when the work load of the department involved indicates need for an additional member of its professional staff," but to leave in the following: "Some may fault a salary arrangement as lacking an incentive to productivity. The desire to provide optimal care of patients motivates the majority of physicians; in medicine there are effective incentives other than financial ones."

3. Voted to reaffirm the following *Statement on Financial Requirements*:

"In each individual institution, the prospective rate should result in apportionment without discrimination among all purchasers of care with equal charges for comparable services."

4. Agreed with AHA's decision not to offer prompt-payment incentives for early payment of hospital bills, or late-payment for unpaid bills.

5. Agreed with AHA that administrative rather than judicial relief is the most feasible approach to correction of abuse of the regulatory process.

6. Approved the policy statement on "The Role of the Foreign Medical Graduate."

7. Approved AHA's endorsement of the Medic Alert Foundation and participation in its activities.

Report of AMA Delegates . . . Received with commendation the report of the New Jersey Delegation to the 1975 AMA Annual Convention, from which the following highlights are noted:

1. Richard E. Palmer, M.D., of Alexandria, Virginia, was selected President-Elect.

2. Annual dues of regular members were increased to \$250 and the House was assured that depleted financial reserves would be restored, that present programs would be continued, and that additional programs, such as those involving malpractice and growing government presence, would be mounted.

3. The House called for the AMA to take immediate action to help ease the malpractice crisis, including formation of an AMA-sponsored professional liability reinsurance company, which will provide backup for those state medical societies who have sponsored their own medical liability insurance programs.

4. The House called for (1) balanced budgets, (2) intensified membership recruitment, (3) continued administrative support of AMPAC, and (4) annual reports on the status of AMA fixed assets and investments.

5. The House endorsed a "policy of aggressive advertising promotion" in AMA publications and urged that the ten specialty journals be placed on a self-sustaining subscription basis or sponsored by the society involved. The Board of Trustees will determine the eventual fate of *Prism* and was authorized to set subscription rates for all AMA publications (including *Today's Health*) except *JAMA* and *the American Medical News*.

6. The Council on Long Range Planning and Development will submit a definitive report at the fall Clinical Meeting in Honolulu which, it is expected, will concern organizational structure, the malpractice crisis, increased government intervention, AMA leadership in medical education, and strengthening AMA resources.

7. The House reaffirmed the AMA's long-standing position that physicians participating in government health insurance programs should be reimbursed on the basis of usual, customary, and reasonable charges and requested the Council on Medical Services to examine the Medicaid and Medicare programs to determine if AMA policy is being met, noting objection to a proposal of payment of Medicare fees based on a national economic index as promulgated in regulations published in the Federal Register.

8. The House unanimously supported the Trustees' actions in opposition to implementation of the National Health Planning and Resources Development Act.

9. The House reaffirmed present AMA policy on PSRO's.

10. In endorsing a series of proposals concerning the malpractice problem, the House stressed that the continued ability of the physicians to provide care to patients was a prime motivating factor, and it was emphasized that work slowdowns were basically a commitment to continued patient care rather than personal financial gain in the traditional sense of a strike — that "the primary commitment of the AMA and its physician members is to the essential medical needs of the people of this nation."

11. The House endorsed a continuation of the fifth pathway concept for determining the qualifications of foreign medical graduates.

12. The House voted to oppose medical manpower legislation before Congress which would require medical students to repay capitation grants to their schools or provide "in-kind" service in areas stipulated by government, and which

would provide federal control of the number and distribution of residencies.

13. The House took the following actions on five resolutions referred to the AMA by MSNJ's 1975 House of Delegates:

(a) Resolution #143 — Federal Regulations Mandating Hospital Utilization or Peer Review Procedures (MSNJ Resolution #32, 1975)

In lieu of Resolution #143, the House reaffirmed Resolution #107 which establishes the position that peer review in federal institutions is needed and desirable and that they should also be subject to JCAH review.

(b) Resolution #144 — Repeal of Earnings Test for Social Security Retirement Benefits (MSNJ Resolution #3, 1975)

The House rejected Resolution #144

(c) Resolution #145 — Amendment of Medicaid Legislation (MSNJ Resolution #7, 1975)

The AMA House of Delegates rejected this resolution.

(d) Resolution #146 — Federal Catastrophic Health Insurance (MSNJ Resolution #9, 1975)

A substitute resolution calling for support of the Comprehensive Health Care Insurance Act of 1975 was adopted in lieu of Resolution #146.

(e) Resolution #147 — National Health Resource Planning and Development Act of 1974 (MSNJ Resolution #29, 1975)

A substitute resolution calling for opposition to the implementation of the legislation, including litigation was adopted in lieu of Resolution #147.

Additionally, the House reaffirmed its position that attending physicians may bill for the services of interns and residents only when rendered under the direct, personal supervision of the attending.

Benjamin Rush House . . . Authorized a \$1,000 contribution to the Pennsylvania Medical Society for use in the restoration of the Benjamin Rush House.

Emergency Medical Technicians . . . Rejected a recommendation from the Committee on Emergency Medical Care that the Medical Practice Act be amended to permit emergency department medical technicians, who hold associate degrees in that field from CMDNJ, to work in hospital emergency departments under supervision of a physician, and directed that the matter be referred to the Council on Legislation to determine whether appropriate legislation should be developed and introduced.

Professional Liability Insurance Crisis . . . Directed that JEMPAC distribute a questionnaire, together with copies of MSNJ's drafts of

legislation on professional liability, to all political candidates before the November election to learn the candidates' stand on the professional liability insurance issue, and that the results of the questionnaire be tabulated and sent to the Joint Ad Hoc Committee on Professional Liability and to the Board of Trustees.

Emergency Department Nurse Training Course . . . Endorsed a projected 160-hour emergency department nurse training course to be sponsored by the Inter-Agency Commission on Emergency Medical Care.

Guidelines for Committee on Medical Defense and Insurance . . . Approved the following recommendation concerning the activities of the Committee on Medical Defense and Insurance:

That the Board of Trustees require the Standing Committee on Medical Defense and Insurance to:

- (a.) Outline its procedures in reaching recommendations in regard to all insurance coverage.
- (b.) Amend its current procedures when indicated.
- (c.) Utilize third party insurance analysts to advise the Committee.
- (d.) Report to the Board and therefore the membership the basis for its conclusions.
- (e.) Develop a budget to accomplish these objectives.

Financial Service for Physicians Initiating Practice in New Jersey . . . Approved the following recommendations relating to a financial service of the BVA Credit Corporation for physicians initiating practice in New Jersey:

That MSNJ agree to act as a focal point for providing the necessary application forms to its inquiring members, but by doing so, incurs no responsibility for their accuracy; nor does MSNJ support, endorse, or in any way guaranty the performance of any of its members who may participate in or utilize any of the financial services offered.

That the Board of Trustees endorse the development of this broad spectrum of financial services and that it be made available to MSNJ members and applicants.

AMA-AHA National Invitational Conference on Professional Liability . . . Authorized David R. Brewer, Jr., M.D. and William J. D'Elia, M.D. to attend (with expenses paid) the AMA-AHA National Invitational Conference on Professional Liability to be held on July 28 in Chicago.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

Has there ever been a graduating class that hasn't been told that the "commencement exercise celebrates not the end of the trail, but the beginning" of a career? Whatever validity there may be to this statement, the 209 graduates of the College of Medicine and Dentistry of New Jersey and their thousands of teachers, friends, and relatives who filled the Garden State Arts Center June 2 did not hear it. Instead, they heard Lawrence L. Weed, M.D., one of the most forceful, most perceptive, and most original commencement speakers in memory.

Dr. Weed, who is professor of medicine and community medicine at the University of Vermont's College of Medicine, is known for his advocacy of record-keeping that will facilitate communications between medical specialties. He told a story, undoubtedly apocryphal but probably not too far from reality.

Warning, in effect, that specialization in medicine was getting out of hand, so that "the distance between physicians and patients continues to grow," he recounted an incident in which a psychiatrist and an internist were both treating a patient, unbeknown to each other. Predictably, they gave the patient conflicting medication.

"The result," Dr. Weed intoned, "was that she got dizzy spells when she brushed her teeth, fell on the bathroom floor, and cracked her skull. She is now in neurosurgery."

He is for specialization, Dr. Weed continued, but within the confines of "team efforts" that will give the patient total care. And, he added, patients should receive copies of their own medical records, so that they will know "what is being done and why it is being done."

Again without mincing words, Dr. Weed suggested that more doctors don't always mean better health care.

"Where in the U.S. is life expectancy the greatest?" he asked. "Why, in North Dakota. And where do you think the doctor-patient ratio is lowest? North Dakota!"

Medical education also came under Dr. Weed's deft diagnosis. It could, he suggested, use some streamlining:

"We stuff students full of millions of answers . . . and they spend the rest of their lives trying to match them up with the right questions. Often they can't."

He proposed, too, a restructuring of curricula so that students spend as much — or as little — time to learn different things as they need, at their own speed. This, he said, could well vary according to the student and the subject matter.

Dr. Weed's remarks gave all a lot to think about, just as graduation — trite though the thought may be — provides an opportunity for taking stock, rethinking, and setting forth on new paths. It is there for practicing professionals no less than for graduates and, of course, for faculty.

There was such an opportunity this month, in Newark. A colloquium on primary care, presented by CMDNJ — New Jersey Medical School's new Office of Primary Health Care Education, was held on September 11 in Newark. Cosponsored by The Medical Society of New Jersey, the New Jersey Academy of Family Physicians, the New Jersey Association of Osteopathic Physicians and Surgeons, and the New Jersey components of the Academy of Medicine, American Academy of Pediatrics, and the American College of Physicians, the session addressed itself to "Understanding Tomorrow's Medicine Today."

The program, developed by Edward A. Wolfson, M.D., M.P.H., acting director of the Office of Primary Health Care Education, had been approved for six hours of credit by the American Medical Association, Category I, by the American Academy of Family Physicians, and for Category 2D credit by the American Osteopathic Association.

Space impedes listing the distinguished speakers and panelists whose topics included, among others, delivering health care in the inner city, the family practitioner's view of the internist, and the role of the Federal government in primary care.

Physicians in day-in, day-out practice may ask why CMDNJ has established the primary health care education office and where it will lead. At the College, we see it as a pilot program that might at some time in the future reach full departmental status. The response of our students to the electives being offered beginning this Fall has been breathtaking.

We see the program as a possible modern answer to the often-asked question, "Where has the general practitioner gone?" Specialization in medicine, of the kind Dr. Weed discussed, has

produced its miracles, but the profession must now also recognize some basics. Medicine must train a significant number of young generalists to understand and apply the breakthroughs of the research to the regular care of the individual and his family.

In short, medicine now needs a body of humanists who can deal with the patient's total environment, physicians who realize that illness may have family, social, and environmental as well as biological roots.

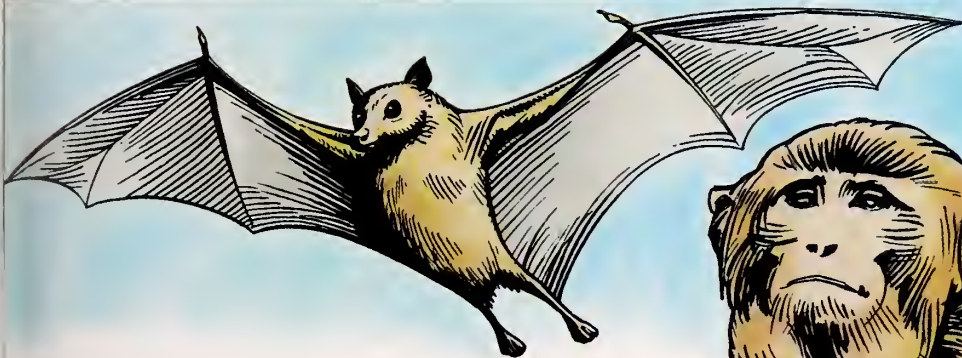
Under Dr. Wolfson's guidance, the program will, it is hoped, eventually turn into a rigorous, across-the-board undergraduate and graduate effort leading to greater educational opportunities. It is a fairly unique and truly exciting approach to basic patient care that should benefit not only New Jersey but, by our example, the entire nation.

Academy of Medicine of New Jersey Award

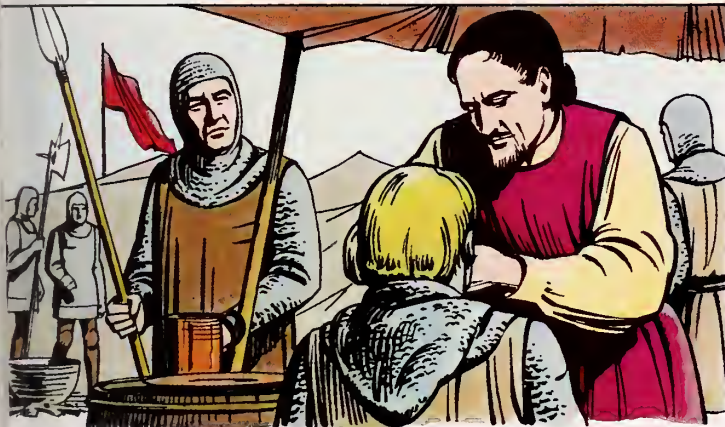


The Academy presented Dr. Eddy Palmer with the 1975 Edward J. Ill Award "for his dedication and extraordinary service to the medical profession and to the citizens of New Jersey." Dr. Palmer, Past-President of the American Society for Gastrointestinal Endoscopy, is Clinical Professor of Medicine, CMDNJ-Rutgers, and in private practice in Hackettstown. He has had published fourteen books and over 450 scientific papers.

The **ALLBEE® with C** Scrapbook of Vitamin Facts & Fallacies

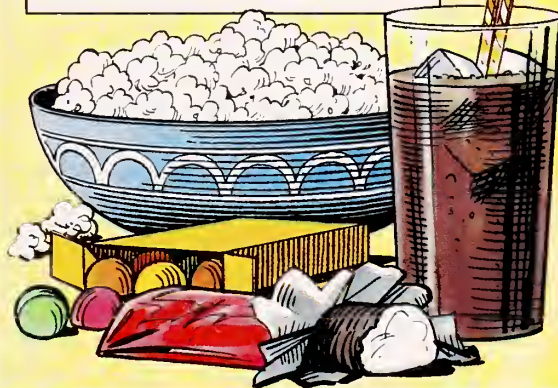


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.



De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.

A 1965 U.S.D.A. survey revealed that American diets were lower in vitamin C than they had been 10 years earlier!



The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	($\frac{1}{4}$ gr.) 16.2 mg.	($\frac{1}{2}$ gr.) 32.4 mg.	($\frac{3}{4}$ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely on usual dosage. Contraindication: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); hypersensitivity to any of the ingredients.

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Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

Five of the eight PSRO areas are now funded by HEW. Our own Support Center contract has been renewed for another year, though with fewer dollars to work with than we had requested. We feel that the labors of so many dedicated people are starting to bear fruit. Here is how New Jersey looks now:

Area I PSRO (Morris, Sussex, Warren) — Planning
Area II Passaic Valley PSRO — Conditional
Area III Bergen County PSRO — Unfunded
Area IV Essex Physicians Review Organization — Planning
Area V Hudson County PSRO — Unfunded
Area VI Union County PSRO — Unfunded
Area VII Central New Jersey PSRO (Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset) — Planning
Area VIII Southern New Jersey PSRO (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Salem) — Planning

Areas I and IV have proposals for Conditional Status filed, and we are expecting them to achieve this shortly. A lot of activity will be going on at the local levels, particularly as Passaic Valley assumes its Conditional role. Your cooperation and attention are directed to Passaic, because it will begin to show what PSRO activity means. Patience is also called for, since these are new ventures, and it will take time for procedures to become operative. Keep in mind that the PSRO will be representing the practicing physicians, and give it a chance to operate. We expect that there will be changes as time goes on as all parties get used to some changes in procedures. Your membership and active participation in the PSROs activities will be helpful.

New Jersey's integrity will be preserved under Public Law 93-641. Health Service Areas will not have to be shared with any other state; the SMSAs were divided at state borders. HSA areas designated: (1) Bergen and Passaic, (2) Essex, Morris, Somerset, Sussex, Union, and Warren, (3) Hudson, (4) Hunterdon, Mercer, Middlesex, Monmouth, and Ocean, (5) Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem. Somerset is the only county which was 'dislocated' from the overall PSRO boundaries. There probably will be a trend in the future to merge PSRO and Health Service Areas.

New Jersey Foundation for Health Care Evaluation officers for 1975-76 are:

President	Emanuel Abraham, M. D.
President-Elect	Charles I. Nadel, M. D.
1st Vice-President	Thomas J. Dougherty, M. D.
2nd Vice-President	Floyd Kregel, D. O.
Secretary	Charles E. Dooley, Jr., M. D.
Treasurer	Charles S. Krueger, M. D.

Congratulations to William D'Elia, M.D., for his diligent work as President during the past year.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. Do you have any reports of tumors being associated with the use of spironolactone?

A recent report appeared in the *Wall Street Journal*¹ stating that a scientific panel is reviewing the safety of spironolactone (Aldactone®) and spironolactone plus hydrochlorothiazine combination (Aldactazide®). A 78-week rat toxicity study conducted by Searle involving high dosages of spironolactone disclosed dose-related increases in the incidence of benign tumors of the thyroid and testes.

As a consequence, the FDA's Cardiovascular Advisory Committee is reviewing the relevance to the continued marketing and/or labeling of spironolactone and is taking another look at its suggested uses.

A Searle spokesman noted that the doses involved were 350 times the normal for human use and previous long-term studies with lower doses didn't show any abnormal thyroid or testicular growths in rats. Such findings also failed to be observed in long-term toxicity studies in rhesus monkeys, a species which metabolizes spironolactone similar to man.

It should be noted that this is only a preliminary study, and as of this writing, no specific warnings have been issued by the FDA or Searle concerning spironolactone.

References

¹Anon: G. D. Searle says panel is reviewing safety of two tension drugs. *Wall Street Journal*, June 5, 1975.

2. Should patients taking anticonvulsant drugs receive vitamin D supplements?

Recent studies indicate that vitamin D (calciferol) must undergo 2 enzymatic hydroxylations before it can function at target cells. Calciferol is transported from the skin or gastrointestinal tract to the liver, where it is converted to 25-hydroxycalciferol. After hydroxylation by the liver, hydroxycalciferol is transported to the kidneys, where it undergoes a second hydroxylation to 1,25-dihydroxycalciferol, which is currently thought to be the final active metabolite of vitamin D. Current evidence suggests that anticonvulsant drugs may disrupt this normal sequence by inducing hepatic enzymes that increase the catabolism of vitamin D and its biologically active products.¹

In a survey of 48 adult epileptic outpatients receiving chronic combined phenobarbital and diphenylhydantoin, Hahn and co-workers² demonstrated significant hypocalcemia in 19 percent, and significantly decreased serum 25-hydroxycalciferol in 33 percent of patients as compared to 38 untreated controls. Similar but less marked change was seen in a group of 13 patients given chronic therapy with either phenobarbital or diphenylhydantoin alone. The effect appeared to be time-dependent, since patients who had received these drugs for a period of six weeks or less had normal serum levels. Subsequently, Hahn and co-workers³ studied 56 children with epilepsy receiving chronic therapy with phenobarbital or diphenylhydantoin or both and 51 controls to determine the effects of anticonvulsant therapy on mineral, vitamin D, and bone metabolism. This study demonstrated that in an ambulatory out-patient juvenile epileptic population, chronic treatment with phenobarbital and diphenylhydantoin, either singly or in combination was associated with significant reductions in serum 25-hydroxycholecalciferol and calcium values and a significant reduction in bone mass. The authors reported that both phenobarbital and diphenylhydantoin employed in the usual clinical dosages appeared to have comparable effects on

serum biochemical measurements and bone density, and these effects were additive when the drugs were used in combination.

Sotaniemi, *et al.*⁴ studied disturbances in calcium metabolism and radiologic changes in the femur of 91 adult epileptic patients on long-term anticonvulsant therapy. Fifty nonepileptic patients served as controls. In general, epileptic patients had reduced serum calcium and phosphorous levels and elevated alkaline phosphatase values. The authors suggested that such abnormalities were related to anticonvulsant-induced vitamin D deficiency.

Latorre and Kenny⁵ found hypocalcemia, hypophosphatemia, and x-ray evidence of rickets in three children undergoing anticonvulsant therapy. Healing occurred in two patients who were maintained on anticonvulsants during two and four months of therapy with vitamin D, calcium, and phosphorous supplements. Thereafter, vitamin D alone maintained the healing. In the third patient, intravenous calcium gluconate (270 mg elemental calcium per 24 hours) over several two to three week periods resulted in healing of rickets and osteoporosis without deleterious side effects.

Several other authors have demonstrated similar adverse effects associated with the use of anticonvulsants.⁶⁻¹⁰

In conclusion, some epileptic patients taking anticonvulsants in high dosage over long periods have developed hypocalcemia and very rarely, rickets or osteomalacia. To prevent this, some clinicians recommend that patients being treated with anti-epilepsy agents (particularly those who may not be receiving adequate nutrition and sunlight) should receive supplemental vitamin D; e.g. 4000 units per week.¹¹

References

¹Anast C S: Anticonvulsant drugs and calcium metabolism. *N Engl J Med* 292:587-588 (March 13) 1975.

²Hahn T J and co-workers: Effect of chronic anticonvulsant therapy on serum 25-hydroxycalciferol levels in adults. *N Engl J Med* 287:900-904 (November 2) 1972.

³Hahn T J and co-workers: Serum 25-hydroxycalciferol levels and bone mass in children on chronic anticonvulsant therapy. *N Engl J Med* 292:550-554 (March 13) 1975.

⁴Anon: Hypocalcemia-osteomalacia. *Clin Alert* 227A (November 29) 1972.

⁵Latorre H and Kenny F: High-dosage intravenous calcium therapy for osteoporosis and osteomalacia in anticonvulsant therapy with hypomobilization. *Pediatrics* 53:100-104 (January) 1974.

⁶Mace J and Schneider S: Diphenylhydantoin and rickets (Letter to Editor). *Lancet* 1:1119 (May 19) 1973.

⁷Borgstedt A D, *et al.*: Long-term administration of anti-epileptic drugs and the development of rickets. *J Pediatr* 81:9-15 (July) 1972.

⁸Medlinsky H: Rickets associated with anticonvulsant medication. *Pediatrics* 53:91-95 (January) 1974.

⁹Christiansen C, *et al.*: Incidence of anticonvulsant osteomalacia and effect of vitamin D: Controlled therapeutic trial. *Br Med J* 695-701 (December 22) 1973.

¹⁰Teotia M, *et al.*: Rickets precipitated by anticonvulsant drugs. *Am J Dis Child* 125:850-852 (June) 1973.

¹¹Anon: *American Hospital Formulary Service*. American Society of Hospital Pharmacists, Washington, D.C. 28:12 1974.

3. Please provide information concerning methyldopa associated with liver damage.

Methyldopa (Aldomet®) is a widely-used and effective antihypertensive agent. There have been several reports of adverse hepatic reactions associated with its use. Most reactions may be classified as (1) slight and usually transient abnormalities in liver tests with no clinical symptoms or signs, or (2) significant hepatic cell injury producing a syndrome with clinical, biochemical, and histopathological changes resembling acute viral hepatitis.

Toghill, *et al.*¹ described twenty patients in whom liver damage appeared to be directly related to the administration of methyldopa. Sixteen had hepatitis-like reactions from which they recovered on stopping methyldopa, and four of these patients had recurrences of jaundice after a second course of drug. Features suggestive of active chronic hepatitis were found in two patients. There was one death from fulminant hepatic failure, and an unsuspected cirrhotic died from superimposed hepatic damage.

Schweitzer and Peters² report an acute submassive hepatic necrosis in a patient who had received methyldopa for ten weeks. The liver lesion was associated with a positive lupus erythematosus preparation, a positive direct Coombs test, and transient portal hypertension. Causal relation between methyldopa and the hepatic necrosis was established by an unequivocal response of transaminase activity to readministration of the drug. The most striking histological feature during the acute phase of the disease was extensive necrosis of liver cells in the periportal areas.

Hoyumpa and Connell³ described three cases of hepatitis following methyldopa administration. Eight to ten weeks after the start of methyldopa therapy, the patients presented with features similar to those of acute viral hepatitis. However, Australian antigen was not detected in the serum;

instead, immunologic disturbances were noted. The first patient subsequently went into hepatic coma and died from massive hepatic necrosis. The second patient had a protracted course but gradually improved. The third patient recovered fully.

Goldstein, *et al.*⁴ investigated the etiology of 21 consecutive cases of active chronic hepatitis; 14 were considered to be drug-induced (five followed ingestion of methyldopa), and seven were of unknown etiology. Cases considered to be drug-induced closely resembled cases of active chronic hepatitis of unknown etiology clinically, biochemically, and histologically. Drug-induced cases showed clinical and biochemical improvement after drug withdrawal, and three months later the change in their liver function was greater than in cases of unknown etiology. One case associated with methyldopa had severe exacerbations of hepatitis on re-exposure to the drug.

Rehman, *et al.*⁵ reported a case where a 51-year-old woman developed jaundice after two separate administrations of methyldopa. The second administration resulted in submassive hepatic necrosis and was fatal.

In conclusion, methyldopa is clearly hepatotoxic and, therefore, caution should be used in giving it to patients with overt liver disease. In patients suspected of having hepatitis-like reactions to methyldopa, avoid rechallenge because of reports of severe exacerbations of hepatitis and fatalities.

References

¹Toghill P J, *et al.*: Methyldopa liver damage. *Brit Med J* 3:545-548 (August) 1974.

²Schweitzer I L and Peters R L: Acute submassive hepatic necrosis due to methyldopa. *Gastroenterology* 66:1203-1211 (June) 1974.

³Hoyumpa A M and Connell A M: Methyldopa hepatitis. *Am J Dig Dis* 18:213-222 (March) 1973.

⁴Goldstein G B, *et al.*: Drug-induced active chronic hepatitis. *Am J Dig Dis* 18: 177-184 (March) 1973.

⁵Rehman O U, *et al.*: Methyldopa-induced submassive hepatic necrosis. *JAMA* 10:1390-1392 (June) 1973.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY — Socorro D. Tamase, M.D., 225 South Crandall, Los Angeles, California 90057. Santo Tomas (Philippines) 1956. Board eligible. Group, solo, partnership, or hospital. Available.

Tser-Fu Huang, M.D., 32-46 69th Street, Woodside, New York 11377. Kaohsiung (Taiwan) 1969. Board eligible. Group or partnership. Available July, 1975.

DERMATOLOGY — Robert Schneider, M.D., 1945-16 Eastchester Road, Bronx, New York 10461. Brussels 1971. Board eligible. Solo, partnership, or group. Available.

FAMILY MEDICINE — Robert J. Breiman, M.D., 7801 NE 4th Court, Apt. S14, Miami, Florida 33138. University of Rochester 1973. Board certified. Group or partnership. Available June 1976.

INTERNAL MEDICINE — Fred H. Hyer, M.D., 6640 SW 5th Street, Hollywood, Florida 33023. CMDNJ 1970. Board eligible. Group or solo. Available August 1975.

Haresh Kantilal Ajmera, M.D., 82 Amity Street, Brooklyn, New York 11201. Bombay University 1969. Subspecialty, gastroenterology. Board certified. Any type practice. Available July 1975.

Nellie Lee, M.D., 175 Hobart Street, Ridgefield Park, New Jersey 07660. Far Eastern (Philippines) 1966. Subspecialty, cardiology. Board certified. Group, partnership, clinic, or solo. Available.

Leslie C. Feigin, M.D., 361 Park Ave, Apt. B-2, Orange, New Jersey 07050. CMDNJ 1973. Board eligible. Group or partnership in northern New Jersey. Available July 1976.

Ishwar V. Thakkar, M.D., 1926 West Harrison Street, Apt. 1110, Chicago 60612. Baroda (India) 1970. Subspecialty endocrinology. Board eligible. Group, associate with teaching hospital. Available July 1976.

NEUROLOGY — Muhammad Aslam, M.D., Mayfair Apts., A-2, May Drive, Schuylkill Haven, Pennsylvania 17972. Nishtar (Pakistan) 1967. Board eligible. Solo or associate. Available June 1975.

Harry L. Bremer, M.D., 3005 Scarborough Road, Cleveland Heights, Ohio 44118. Hahnemann 1971. Board eligible. Partnership. Available July 1976.

OBSTETRICS AND GYNECOLOGY — Jagannath Das, M.D., 3384 Scranton Road, Cleveland 44109. Calcutta Medical College (India) 1959. Board eligible. Group or partnership. Available July 1975.

Jiunn Sheau Cheng, M.D., 1757 East Raleigh Court, Apt. 168-A, Ocean, New Jersey 07712. Taiwan 1964. Board eligible. Group or partnership. Available July 1975.

Chia Sherng Shu, M.D., 1564 St. Johns Place, Brooklyn, New York 11213. Taipei (Taiwan) 1968. Board eligible. Solo, group, or partnership. Available.

Lyle J. Breitkopf, M.D., 519 Maitland Avenue, Teaneck 07666. SUNY (Downstate) 1960. Board certified. Academic position (full-time) or group practice. Available.

OPHTHALMOLOGY — Ronald S. Lorfel, M.D., 1505 Vicksburg St., Belleville, Illinois 62221. Wayne State University 1970. Board eligible. Solo, associate, or group. Available July 1976.

ORTHOPEDIC SURGERY — Cornelius I. Nicoll, M.D., 117 Westview Road, Montclair 07043. Bucharest (Romania) 1963. Group, partnership, hospital, or solo. Available July 1975.

Ira Spar, M.D., 26 Allston Street, Apt. 1, Allston, Massachusetts 02134. George Washington 1968. Board eligible. Group, partnership, or hospital. Available.

Ilhwan Kim, M.D. 1935-16-C, Eascheter Road, Bronx, New York 10461. Seoul (Korea) 1969. Solo or group. Available July 1976.

PATHOLOGY — Yogini J. Shroff, M.D., 3 Blackwell Avenue, Morristown 07960. B.J. Medical (India) 1968. Board eligible — AP and CP. Group, partnership, hospital, research, or teaching. Available July 1975.

M. Netto, M.D., 125 Heather Drive, Rochester, New York 14625. Madras (India) 1962. Board certified. Solo, group, associate, or hospital. Available September 1975.

PEDIATRICS — Ferdous Kazemi, M.D., Regency Village, Apt. 13G, Route 22, North Plainfield 07060. Teheran 1969. Board eligible. Partnership, full or part-time hospital, pediatric ambulatory. Available July 1975.

Surendra C. Sheth, M.D., 85-20 160th Street, Jamaica, New York 11432. Baroda (India) 1970. Board eligible. Solo, partnership, hospital. Available.

PSYCHIATRY — Pawan Chadha, M.D., 118 East Oakland Street, Monticello, Arkansas 71655. Delhi (India) 1969. Group, partnership, solo, or community mental health center. Available July 1975.

SURGERY — Hossein Faiz, M.D., Medical College of Pennsylvania Hospital, 3300 Henry Avenue, Philadelphia 19129. Teheran 1967. Subspecialty, vascular surgery. Board eligible. Solo, association, or group. Available July 1975.

Allen W. Leadbetter, M.D., 1930 Planters Drive, Charleston, South Carolina 29407. University of Maryland 1969. Board eligible. Solo, partnership, or group. Available summer 1976.

Yusooff T. Allian, M.D., 26710 Golfview Rd., Dearborn Heights, Michigan 48127. Far Eastern (Philippines) 1967. Subspecialty, cardiothoracic surgery. Board certified in general surgery. Group, partnership, association, or solo. Available July 1976.

Achyutananda Roy, M.D., 5601 Boulevard East, Apt. 20-I, West New York, New Jersey 07093. Calcutta (India) 1961. Board certified. Group, partnership, or solo. Available.

Sheldon Kneller, M.D., Box 542, Martin Army Hospital, Fort Benning, Georgia 31905. Einstein (NY) 1968. Subspecialty, vascular surgery. Board eligible. Group or partnership. Available August 1976.

Shuban K. Moza, M.D., 1819 Williamsbridge Road, Apt. 2-A, Bronx, New York 10461. Kashmir (India) 1965. Board eligible. Group or partnership. Available.

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Psychiatry and the Law: Insanity Defense in New Jersey

Psychiatrists are frequently called to assist the courts in criminal cases since psychopathology, which is commonplace in persons accused of crimes, may serve as the basis for the defense, according to our legal system. Yet, the psychiatrist in the courtroom often appears to be a paradox to the legal machinery and the adversary system. Courtroom procedure demands objective proofs which are understandable in terms of logically and consciously derived behavior. Psychiatry, however, is often a subjective art, based on the less clearly defined workings of the unconscious mind, which may be more compelling determinants of behavior. The law recognizes this fact, to an extent, and provides for an exception to the hearsay rule¹ by permitting the psychiatrist to testify about the history obtained from the patient. Objective data are frequently limited to what the trained eyes and ears perceive from the actual interview and what the individual "tells" the psychiatrist. There are no "hard" objective findings such as x-rays, blood chemistry changes, and so on, which are less vulnerable to subjective influences. Jurists often complain that psychiatry is an inexact science. More to the point is that the human mind is inexact and difficult to quantify. Yet, the psychiatrist is expected to state whether or not the alleged criminal was "insane" at the time of the crime with few objective findings to substantiate his statement and without having been able to examine the subject at the moment of the criminal act.

Definition of Insanity — Insanity in New Jersey is defined by the M'Naughten Rule.² The subject is considered insane, if, at the time of the alleged criminal acts, "he was laboring under such a deficit of reason from disease of the mind as not to know the nature and quality of the act; or, if he did know it, that he did not know he was doing what was wrong." The "nature" of an act means that the subject is able to perceive the physical characteristics of his act. For example, if a person knows that a knife cuts skin, then he knows the "nature" of his act of flinging a knife at a victim. The quality of an act is generally

considered to be the effect on the victim or consequences to the victim.³ If that person knows that victim will be injured by his flinging a knife, then he knows the "quality." "The act was wrong" clause is considered in its concrete sense and is not to be taken as an abstract concept.

Under the law, people are assumed to be sane, therefore, the burden of proving insanity falls upon the defense. This definition has its significant limitations for the psychiatrist because of the nature of unconscious psychodynamics which the M'Naughten Rule, in its appeal to the conscious and rational mind, disregards. As an example, a schizophrenic individual may experience "command" auditory hallucinations which order him to kill another person because that person is, in some way, evil in this individual's aberrant thinking. The psychotic individual operating on the basis of this hallucinatory and delusional system, *still may know that the murder is wrong and the weapon used in the murder had lethal potential*. To the psychiatrist, the individual is insane and was insane at the time of the crime, which was committed on the basis of his unreal and psychotic delusions and hallucinations. In a strict interpretation of the M'Naughten Rule, however, the individual did understand the nature and quality of his act, and knew that it was wrong, though in his disturbed mind it was justified. Within his delusional system, however, the individual may have operated in an otherwise logical manner, planning the murder with careful and calculated intent and with a view to avoiding detection and apprehension following the crime.

Psychiatrists as Expert Witnesses — Psychiatrists who serve as expert witnesses, for the prosecution or the defense, are expected to examine the subject and to report findings to the best of their professional ability. The mystique of the expert witness is that he presents objective and unbiased findings. However, based on our adversary system and the law, we find that there are two expert witnesses who oppose each other and who bring to the court "objective findings"

that often differ. We feel that it is unrealistic, and probably impossible within our adversary system, for the psychiatrist to remain neutral and totally dispassionate. The psychiatrist, as a human being, is governed by the same unconscious dynamics affecting all human beings over which they have only limited voluntary control. These factors are often crucially important yet are given little consideration within the framework of a legal system, which is based on the rational, logical, and "conscious" behavior of human beings.

Within our adversary system, it is doubtful that the psychiatrist, consciously or unconsciously, can avoid becoming an advocate. Furthermore, we contend that the psychiatrist may be doing a disservice to society or the alleged offender in this system (depending on who engaged his services) if he does not enter into an advocacy role, since the opposition is certainly going to expose all the data in its favor. There are those who oppose this contention.⁴

Does Insanity Continue? — Another enigma to those involved in the law and forensic psychiatry concerns the alleged offender who is found not guilty by reason of insanity. We now must determine whether or not his "insanity" continues, a dilemma based on the fact that the law provides for society to be protected from those who are ill, as well as those who are "bad." We must determine whether or not such a person has been sufficiently restored to reason so as not to constitute a danger to society. The psychiatrist is faced with the difficult task of predicting violent or deleterious behavior, yet our ability to reliably predict future violence is in doubt.⁵ If the insanity continues, the subject must be committed to the New Jersey State Hospital at Trenton until "such time as he may be restored to reason."⁶

At this point, it must be noted that the subject is not considered "restored to reason" as long as his underlying condition still is present, even though a remission phase of his illness exists. Furthermore, he cannot be released except by order of the committing court.⁷ This "Maik Decision" has been somewhat softened by the "Carter Decision"⁸ which states that the subject may be released if his underlying disease has been cured or "effectively neutralized." The

meaning of this latter phrase has not yet been determined. The Carter Decision also states that a mere remission is not enough. This neutralization is apparently something less than a cure which eliminates the underlying illness, but is more than remission which connotes a temporary state. The mere abatement of symptoms absents an expectation that reason will prevail and provides no assurance that the subject is safe from doing harm. "Neutralization, then, could be a state of recovery more permanent than that brought about by mere remission of symptoms or control of the patient's environment. It could be something less than a complete 'cure,' allowing for the limited possibility of relapses. The individual whose condition is 'neutralized' can cope with the world as it is, without supervision and guidance."

Some physicians may throw up their hands, question getting involved with all these legal complications and spending frustrating hours attempting to operate within a legal framework that tends to ignore modern psychiatric knowledge. The basic aim of law is justice (a social aim), while scientific aim is knowledge or truth. We feel that physicians have an obligation to help people and the physician, as an expert witness in the courtroom, may be all important in the subject's life.

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¹Cleary E W: *McCormick's Handbook of the Law of Evidence*. St. Paul, West, 1972.

²Rex vs McNaughten. 10 Clark and Finelly. House of Lords Cases, 200.

³Davidson H: *Forensic Psychiatry*, New York, Ronald, 1965.

⁴Slovenko R: *Psychiatry and the Law*. Boston, Little Brown, 1973.

⁵Task Force Reports: *Clinical Aspects of the Violent Individual*. Washington, American Psychiatric Association, 1974.

⁶NJSA 2A:163-3.

⁷State vs Maik. 60 New Jersey 199,220 (1972).

⁸State vs Carter, 64 New Jersey 382 (1974).

S.F. Kuvin, M.D. and H.J. Shwed, M.D.
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CLINICAL NOTES

Appendiceal Polyps

Thomas K. Rathmell, M.D./Trenton

The best definition of a polyp is that given by Smith, Beamer, Vellios, and Shulz¹. A polyp is a gross descriptive term which may be applied to any mass which is elevated or projects above a normal surface level.

It is rather difficult to isolate the subject of appendiceal polyps from polyps of the gastrointestinal tract. Gastrointestinal polyps may be classified as 1) sessile (villous) polyps or 2) pedunculated (adenomatous or villous) polyps — as modified from Robbins.²

Table
Clinical Syndromes with Polyps

Name	Characteristics
Familial Polyposis	Malignant; dominant; 2nd and 3rd decade
Peutz-Jegher's Syndrome	Often benign; pigmentation
Gardner Syndrome	Other tumors (skin, soft tissue, bone)
Turcot Syndrome	Brain tumor; recessive
Juvenile Polyposis	Involves caecum; under age 20

Forty years ago, appendiceal polyps were a popular pathologic subject, reported by Collins³ and Norment⁴ in 1932. Collins⁵ summarized his experience of 40 years by reporting 57 polyps in 71,000 appendices (0.0008 percent). Hameed⁶ erroneously gives this percentage as 0.08 percent when referring to Collins work.

Qizilbash⁷ who reported 19 cases and used the term "hyperplastic (metaplastic) polyps," considered appendiceal polyps as a fairly common finding. He studied their Paneth cells and disagreed with the above authors, all of whom considered the finding of an appendiceal polyp as a rare experience. Lane, Kaplan, and Pascal⁸, in their report on colonic lesions, considered metaplastic or hyperplastic nodules as distinct from adenomatous polyps.

*Courtesy John Wise, M.D.

**Courtesy Raymond A. McCormack, M.D.

Case Reports

At the Mercer Medical Center during the past 24 years (1950-1974), we have examined 5,680 appendices, including specimens from incidental appendectomy in association with hysterectomy. Two polyps of the appendix have been noted (0.00035 percent).

The first case* was in a 26-year-old male. The viscus (Figure 1) showed a polyp which measured 2.6 cms. by 0.8 cms. It also was ulcerated and had histological features of Crohn's disease (regional ileitis). It was regarded as a pseudo-polyp having resulted from excessive peristalsis of the ulcerated appendiceal mucosa. The wall of the appendix was 1.5 cms.



Figure 1 — Pseudopolyp of appendix with ulcerative Crohn's disease



Figure 2 — Appendiceal polyp (malignant) with associated familial polyposis and malignancy of colon.

The second case** was in a male of 55 years, who had familial polyposis of the colon as well as a

napkin-ring type of carcinoma of the sigmoid. A similar case was reported by Collins in 1932. The appendix was seen in association with a resection of the caecum and right colon (Figure 2). Histologically, the polyp was malignant. It was 0.5 x 0.6 cms. in size. It is regarded as similar to the other malignant polyps which were in the colon.

Discussion and Conclusion

It would appear therefore that so-called metaplastic and hyperplastic polyps of the appendix are not true polyps. Appendiceal polyps, which we believe, are quite rare, show no sex preponderance or other specific symptoms. We agree with Hameed⁶ that they cannot be diagnosed prior to visualization of the appendix.

Although a vestigial organ, the appendix may participate in systemic reactions of the gastrointestinal tract.

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INFORMATION FOR READERS AND CONTRIBUTORS

The Journal, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts (original and one copy) submitted to *The Journal* must be typewritten, *double-spaced* on letter size (about 8½ x 11 inch) paper, and forwarded to the

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Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original drawings.

Bibliography: Format used in JAMA must be followed. References should be numbered in order of citation in the text.

Reprints: Reprints may be ordered after the author has been notified that his article has been selected for a specific issue of *JMSNJ*.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P.O. Box 904, Trenton, New Jersey 08605

LETTERS TO THE JOURNAL

Wanted for Murder

August 4, 1975

Dear Editor:

The United States Department of Justice, Federal Bureau of Investigation, would be appreciative if you will bring the following information to the attention of the readers of your *Journal*.



Vincent James DeSena
(1961 photo)
FBI no. 2,961,416

Vincent James DeSena, who has reportedly been plagued with a variety of medical problems, is currently being sought by the FBI for unlawful interstate flight to avoid prosecution for the stabbing murders of his wife and daughter in Orange, New Jersey, on February 25, 1969. He has a long medical history, including poor eyesight, hemorrhoids, swelling of facial glands, an unconfirmed heart condition, and mental instability. He has attempted suicide and has been in a mental institution.

DeSena is a white male, born December 25, 1920, in New York — 5'5" tall, 135 pounds, slender build, brown receding hair, brown eyes, dark complexion. He has a scar across the front of his neck, a tattoo of wings and "USAF" on his left

forearm, a bracelet on his left wrist, and a cross on his right forearm. He has employed physical disguises and uses the name Frank Marino as an alias.

The fugitive's medical condition suggests that he might require medical attention on a continuing basis. Any one with information concerning him should take no action other than to contact the nearest office of the FBI.

(signed) Paul J. Mohr,
Special Agent-in-Charge

"Puff and Sip" Apparatus

June 25, 1975

Dear Editor:

There have been several inquiries since my paper: "The Role of the Physiatrist in the Care and Treatment of the Spinal Cord Injured Patient" which appeared in the March 1975 issue (*JMSNJ* 72:189) as to where a "Puff and Sip" breath-controlled apparatus for operation of a motorized wheelchair can be purchased.

The apparatus is available through The National Institute for Rehabilitation Engineering in Pompton Lakes, and any information regarding it can be obtained from that source.

(Signed) Richard A. Sullivan, M.D.
Medical Director

The Kessler Institute for Rehabilitation

ANNOUNCEMENTS

Review Course for Practicing Physicians

An intensive review course in basic principles and new techniques of primary care will be offered by the Department of Continuing Medical Education of Howard University College of Medicine from September 8 to 13, at the Howard University Hospital. Topics will include: Early Signs of Cancer, Evaluation of Breast Masses, Fetal Presentation at Delivery,

Physical Medicine, Psychosomatic Detection in Children, Renal Disease, and the Family Physician in Emotional Crises. Tuition is \$175, and request has been made to the American Academy of Family Physicians for 45 credit hours. For additional information, please communicate with Wm. E. Matory, M.D., Program Director, College of Medicine, Howard University, Washington, D.C. 20059.

Pulmonary Disease Series

Following is a list of the monthly lectures in pulmonary diseases to be sponsored jointly by the Veterans Administration Hospital in East Orange and the New Jersey Medical School in Newark:

- Sept. 17—Membrane Oxygenation for Acute Respiratory Insufficiency
- Oct. 15—Tracheal Tumors: Aspiration for Diagnostic Specimens
- Nov. 19—Heterogeneity of ACTH: Relevance to Physiologic and Pulmonary Disease
- Dec. 17—Mechanisms of Lung Injury in Obstructive Lung Disease
- Jan. 21—Interstitial Disease of the Lung
- Feb. 18—Protease Inhibitors and Pulmonary Disease
- Mar. 17—Pulmonary Cardiogenesis
- Apr. 21—Categories of Pulmonary Disease Measured by Functional and Laboratory Data
- May 12—Rehabilitation of Chronic Pulmonary Patient

All sessions will be held at 11:30 a.m. in the third-floor auditorium of the East Orange Veterans Administration Hospital. For additional information, please communicate with L. Fred Ayvazian, M.D., Chief of the Pulmonary Disease Section at the hospital.

Seminar on Head and Neck Tumors

From October 2 to 4, 1975, the Section on Otolaryngology of the New Jersey Medical School and the Department of Otolaryngology of the Newark Eye and Ear Infirmary will sponsor the W. Franklin Keim Memorial Seminar on the pathology and treatment of head and neck tumors. Tuition is \$100 (\$25 for residents and interns) and includes luncheons. A non-refundable \$25 fee is required for registration. The program is acceptable for AMA Category I accreditation. For additional information, please communicate with Ki H. Han, M.D., Director, Department of Otolaryngology, Newark Eye and Ear Infirmary, 15 South 9th Street, Newark 07107.

Course in Hematology

The American College of Physicians, in conjunction with Jefferson Medical College, will sponsor a three-day graduate course for internists, October 8 to 10, 1975, in new concepts in basic and applied hematology. The course is designed to present current concepts of the pathophysiology, diagnosis, and treatment of hematologic problems with emphasis on the

relationship between new advances in the basic sciences and an understanding of disease processes. Primarily a clinical approach will be taken toward the study of red blood cells, hemostasis, and white blood cells and leukemia. The program has been approved for Category I requirements for the AMA Physician's Recognition Award. For further information and registration please write to the Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia 19104.

Psychosomatic Disease Conference

A two-day clinical conference entitled "Emotions and Illness: Current Views of Psychosomatic Disease" is scheduled for October 9 and 10, 1975, at the Friends Hospital in Philadelphia. Registration opens at 8 a.m. and the first presentation is scheduled for 9:30. Topics to be covered on the first day include theoretical concepts in psychosomatic medicine, historical family systems approach to coronary heart disease and to cancer, and behavior types. Following luncheon there will be a panel discussion on "Cardiovascular Disease: Psychologic Aspects." Scheduled as the dinner speaker is Hans Selye, M.D., whose topic is stress and psychosomatic medicine. The second day's speakers will address the session on psychosomatic specificity, the nature of psychosomatic phenomena, and the role of the family in the treatment of psychosomatic disorders. The afternoon's panel discussion will be on clinical applications of psychosomatic theory. For additional information, please communicate directly with Mr. William S. Fall, Director of Community Relations, The Friends Hospital, Roosevelt Boulevard and Adams Avenue, Philadelphia 19124.

Course in Gynecologic Laparoscopy

On October 16 and 17, 1975, the New Jersey Fertility Foundation will sponsor a course in gynecologic laparoscopy. The sessions will be held at the Memorial General Hospital in Union, New Jersey, and will consist of lectures and demonstrations on the first day, and operating room experience with six cases on the second day. The registration fee is \$250 and includes luncheon. Attendance will earn 16

Category I AMA credits. For additional information, please communicate with Sidney A. Wilchins, M.D., 14 East Westfield Avenue, Roselle Park, New Jersey 07204.

Review Courses for Board Examinations

The University of Miami School of Medicine (Division of Continuing Medical Education) is offering two courses specifically designed for physicians preparing for specialty board examinations — one in obstetrics and gynecology, to be held October 18 to 23 in Key Biscayne, Florida, and one in basic neurology for psychiatrists, to be held February 23 to 27 in Miami Beach, Florida. Information is available from the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.

Clinical Application of Intra-Aortic Balloon Pump

A course in the clinical application of the intra-aortic balloon pump will be held November 14 and 15 in Bal Harbour, Florida, under the sponsorship of the University of Miami School of Medicine. Tuition is \$140 (\$75 for students, nurses, and technicians). The course is designed to provide cardiologists, cardiac surgeons, and allied professionals with information on the newest developments in the treatment of shock and heart failure. Practical aspects of the intra-aortic balloon pump in cardiogenic shock and cardiac surgery will be stressed. Information can be obtained from the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.

Medicolegal Seminar

With the assistance of the Office of the Chief Counsel of the American Medical Association, the Inter-Agency Commission on Emergency Medical Care has arranged a medicolegal seminar to be held on December 3, 1975 at the Cherry Hill Inn, Cherry Hill. Subjects to be discussed are patients' rights, standards of care and patterns of negligence, ethical considerations and legal consequences, and legal principles relating to the division of responsibility between

physicians and the institution. Brochures and registration forms are being forwarded to all physicians and hospitals. For additional information, please communicate with Dr. Jack R. Karel, M.D., 15 North Avenue, Hillside 07205.

Continuing Education Courses in Florida

The Division of Continuing Medical Education of the University of Miami School of Medicine has announced the following seminars for January 1976:

Jan. 5 to 8—Pediatric Nephrology (Sponsored by the Department of Pediatrics, Division of Pediatric Nephrology) Bal Harbour, Florida

Jan. 20 to 23—Pathology (Sponsored by the Department of Pathology) Miami Beach, Florida

Jan. 23 to 25—Anatomic Pathology (Sponsored by the Department of Pathology, Florida Society of Pathologists, the American Society of Clinical Pathologists, and the University of Florida College of Medicine) Miami Beach, Florida

Each of the programs is accredited for AMA Category I. For information please write to the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.

Modern Neurology

The Department of Neurology of the University of Miami School of Medicine has announced a course in practical modern neurology to be held February 2 to 6 in Miami Beach, Florida. The course is designed to provide practical approaches to the management of common neurological problems. It is directed primarily to internists, generalists, psychiatrists, physiatrists, orthopedic surgeons, and ophthalmologists who wish to improve their capability in handling patients with neurological disease. Please write to the Division of Continuing Medical Education, University of Miami School of Medicine, P.O. Box 520875 Biscayne Annex, Miami, Florida 33152.

Teaching Seminar on Proctology

The congress and teaching seminar of the International Academy of Proctology will hold its

1976 session in India — Bombay, Jaipur, Agra, and New Delhi — from March 17 to April 4. The faculty will be composed of physicians in India, the United States, and other countries in Europe and Asia. For information on the scientific programs and that relating to transportation and accommodations, please write to the Executive Offices, International Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York 11355, attention Alfred J. Cantor, M.D., Executive Officer.

Neuro-Otolaryngology Sessions

The University of Pittsburgh School of Medicine announced a course in clinical neuro-otolaryngology for March 25 to 27, 1976, at the Eye and Ear Hospital in Pittsburgh. The course is designed for the practicing otorhinolaryngologist or neurologist and for residents in training, to aid in the understanding of various neurological aspects of otorhinolaryngologic disorders. The focus will be on clinical evaluation and management. Topics covered include disorders of the vestibular system, audition, taste, olfaction, speech, swallowing, and the facial nerve. There will be formal presentations, but the emphasis will be on panel conferences with case presentations. All sessions are acceptable for AMA credit hours in Category I. For additional information, please communicate with Sidney N. Busis, M.D., Eye and Ear Hospital of Pittsburgh, Pittsburgh, Pennsylvania 15213.

New Jersey Institute of Ultrasound in Medicine

As a direct affiliate of the American Institute of Ultrasound in Medicine, the New Jersey Institute of Ultrasound in Medicine recently has been established. Interested physicians, engineers, and technologists are welcome to join the Society. The Academy of Medicine of New Jersey has agreed to provide administrative and secretarial support. Application forms and further information may be obtained by writing to the Institute at 2424 Morris Avenue, Union, New Jersey 07083 — (201) 687-8780. Educational and scientific programs are planned for the coming academic year, and it is anticipated that approval will be granted for AMA Category I credits.

Correction

Our readers' attention is called to a misstatement in the "Therapeutic Drug Information" column in the May 1975 issue of *JMSNJ*, page 438, question #3, end of line 2 and half of line 3 of paragraph 4 of the answer. The wording within the parenthesis is incorrect and should read (Lincocin® which has been marketed for the last several years).

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Sept.

12 Family Practice Seminars

19 12:30-1:30 p.m. — Overlook Hospital, Summit

26 (Sponsored by Family Practice Residency Program and AAFP)

13 Exercise Stress Testing and Coronary Artery Disease

7:45 a.m.-5:30 p.m., The Medical Center at Princeton (Sponsored by The Medical Center at Princeton, Rutgers Medical School, and The Center for Continuing Medical Education)

15 Family Practice Psychiatric Case Discussions

30 12:30-1:30 p.m. — Overlook Hospital, Summit

(Sponsored by Family Practice Residency Program and AAFP)

15 Pediatric Happenings

22 12:30-1:30 p.m. — Overlook Hospital, Summit

29 (Sponsored by the Department of Family Practice and Pediatrics and AAFP)

- 16 **Emergency Medicine**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)
- 16 **Orthopedic Problems in Family Practice**
8:30-9:30 a.m. — Irvington General Hospital
(Sponsored by Irvington General Hospital and Academy of Medicine)
- 16 **Anesthesia for Neurosurgery: Co₂, B.P., and Drugs**
8:00 p.m. — Ramada Inn, Clark
(Sponsored by New Jersey State Society of Anesthesiologists and Academy of Medicine)
- 16 **Survey of Allergy-Immunology**
23 11 a.m.—St. Elizabeth Hospital, Elizabeth
30 (Sponsored by Elizabeth Tri-Hospital Residency Program and AAFP)
- 16 **Programed Instruction in EKG Interpretation**
23 8 a.m.—Overlook Hospital, Summit
30 (Sponsored by Overlook Hospital and AAFP)
- 17 **Regionalized Perinatal Care**
6:30 p.m. — Holiday Inn, East Orange
(Sponsored by Academy of Medicine)
- 17 **Clinical Endocrinology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Academy of Medicine)
- 17 **Clinical Application of Angiography**
10 a.m. — St. Michael's Medical Center, Newark
(Sponsored by St. Michael's Medical Center)
- 18 **Use of Antimicrobials Currently on the Market**
8 p.m. — Ocean Point Nursing Home, Somers Point
(Sponsored by AAFP and Academy of Medicine)
- 18 **Antibiotics — Mode of Action, Indications**
8-10 p.m., Green Point Nursing Home, Somers Point
(Sponsored by Atlantic County Chapter, AAFP)
- 19 **Liver Surgery**
12 Noon — Freehold Area Hospital
(Sponsored by Academy of Medicine)
- 19-21 **Ignatz Semmelweis Seminar on Progress in Maternal and Fetal Medicine**
Playboy Club Hotel, Great Gorge
(Sponsored by CMDNJ-New Jersey Medical School, Roche Medical Electronics Company, and Academy of Medicine)
- 21 **Diabetes Seminar**
9 a.m.-5 p.m.—Sheraton-Heights Motor Hotel, Hasbrouck Heights
(Sponsored by Saddle Brook General Hospital and Academy of Medicine)
- 22 **Breast Cancer**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Academy of Medicine of New Jersey)
- 22 **Bone Imaging with Technetium Labeled Compounds**
7 p.m. — Englewood Men's Club
(Sponsored by Englewood Surgical Society and Academy of Medicine)
- 23 **Unconscious Dynamics in the Wish to Abort**
8 p.m. — One Cherry Hill, Cherry Hill
(Sponsored by Institute of Pennsylvania Hospital and Academy of Medicine)
- 24 **Radiology of the Gastrointestinal Tract**
10 a.m. — St. Michael's Medical Center, Newark
(Sponsored by St. Michael's Medical Center)
- 24 **Clinical Endocrinology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)
- 24 **Myofunctional Therapy Controversy**
9 a.m.-12 Noon — Mountainside Hospital, Montclair
(Sponsored by Dental Section, Academy of Medicine)
- 24 **Lower Endoscopy**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 24 **Immunoproliferative Disease and Lymphoma**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
- 24 **Huntington's Disease**
1 p.m. — VA Hospital, Lyons
(Sponsored by VA Hospital and Academy of Medicine)
- 24 **Congestive Heart Failure and Hypertension**
6:30 p.m. — Bridgeton Hospital
(Sponsored by Bridgeton Hospital)
- 24 **Family Practice/Multiple Discipline Conference**
12:30-1:30 p.m. — Overlook Hospital, Summit
(Sponsored by Family Practice Residency Program and AAFP)
- 24 **Family Practice Refresher Program**
8:30 a.m.-4:00 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and CMDNJ, Rutgers Medical School)
- 25 **Advances in Immunology**
4-6 p.m. — Institute for Medical Research, Camden
(Sponsored by Institute for Medical Research and AAFP)
- 26 **Congestive Heart Failure**
12 noon — Montclair Community Hospital
(Sponsored by Academy of Medicine)
- 30 **Management of Difficult Psychiatric Patient**
2-3:30 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- Oct.**
- 1 **New Medicolegal Crises**
1-5:30 p.m. — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic and AAFP)
- 1 **Review of Internal Medicine**
8 Sheraton Inn, Newark Airport, Elizabeth
22 (Sponsored by Academy of Medicine and
29 CMDNJ-New Jersey Medical School)
- 1 **Venereal Disease in Office Practice**
8 **Immunization 1975**
15 **Sleep Disorders**

- 22 **Musculo-Skeletal Pain**
29 **Pain syndromes Involving the Face and Head**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
- 2-4 **Trauma**
Martland Hospital, Newark
(Sponsored by New Jersey Medical School and NJAFP)
- 3 **Weekly Family Practice Seminars**
10 12:30-1:30 p.m., Overlook Hospital, Summit
17 *(Sponsored by Family Practice Residency Program and AAFP)*
24
31
- 4 **Surgical Treatment of Gastric and Duodenal Ulcers**
8:45 a.m.-2 p.m. — Newark Beth Israel Medical Center
(Sponsored by Academy of Medicine)
- 6 **Pediatric Happenings**
13 12:30-1:30 p.m. — Overlook Hospital, Summit
20 *(Sponsored by Departments of Family Practice and Pediatrics and AAFP)*
27
- 7 **Emergencies in the Ambulatory Setting**
9:30 a.m.-10:30 a.m. — Overlook Hospital, Summit
(Sponsored by Departments of Family Practice and Community Medicine and AAFP)
- 7 **Survey of Allergy-Immunology**
11 a.m. — St. Elizabeth Hospital, Elizabeth
(Sponsored by Elizabeth Tri-Hospital Residency Program and AAFP)
- 8 **Anesthesia Conferences**
8-9:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
- 8 **Aneurysms**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 8 **Child Abuse — A Community Problem**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 8 **Family Practice Multidiscipline Conference**
22 12:30-1:30 p.m. — Overlook Hospital, Summit
(Sponsored by Family Practice Residency Program and AAFP)
- 9 **Acute and Chronic Brain Disease**
6:30 p.m. — Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)
- 10 **Advances and Controversies in Pediatrics**
9 a.m.-12 noon — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 14 **Chest X-Rays in the Ambulatory Patient**
21 8-9 a.m. — Overlook Hospital, Summit
28 *(Sponsored by Department of Family Practice and AAFP)*
- 14 **Family Practice Psychiatric Cases**
28 12:30-1:30 p.m. — Overlook Hospital, Summit
(Sponsored by Family Practice Residency Program and AAFP)
- 15 **Didactic Psychiatry**
19 12:30-1:30 p.m. — Overlook Hospital, Summit
(Sponsored by Department of Family Practice, Psychiatry, and AAFP)
- 15 **Management of Renal Insufficiency**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 18 **Respiratory Therapy Symposium**
8:30 a.m.-1:00 p.m. — St. Barnabas Hospital, Livingston
(Sponsored by New Jersey State Society of Anesthesiologists)
- 20 **Acute Renal Failure**
12:00-1:00 p.m. — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 29 **Hodgkins' Disease and Lymphoma**
1:00 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 29 **Acute Psychiatric Problems**
6:30 p.m. — Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)
- Nov.
- 4 **Emergencies Seen in the Ambulatory Setting**
9:00 a.m.-10:30 a.m. — Overlook Hospital, Summit
(Sponsored by Departments of Family Practice and Community Medicine and AAFP)
- 4 **Survey of Allergy-Immunology**
11 11 a.m. — St. Elizabeth Hospital, Elizabeth
18 *(Sponsored by Elizabeth Tri-Hospital Residency Program and AAFP)*
25
- 5 **Review of Internal Medicine**
12 Sheraton Inn, Newark Airport, Elizabeth
26 *(Sponsored by Academy of Medicine and CMDNJ-New Jersey Medical)*
- 5 **Trends in Geriatric Psychiatry**
3:00-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 5 **Advances in Understanding and Treating Asthma**
12 **Dementias Encountered in Medical Practice**
19 **Psychiatric Disorders in Late Life**
26 **Stroke; Warning Signs and Prevention**
9:00-11:00 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
- 12 **Anesthesia Conferences**
8-9:30 p.m., West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
- 12 **Upper Endoscopy**
1:00 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 13 **Radiology Diagnosis**
6:30 p.m., Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)
- 17 **Gallstones: A Medical Disease**
12:00-1:00 p.m. — Montclair Community Hospital

(Sponsored by Montclair Community Hospital and Academy of Medicine of New Jersey)

- 19 New Jersey Regional Meeting
American College of Surgeons

- 26 Diagnosis of Pelvic Disease-Office Gynecology
6:30 p.m., Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)

Dec.

- 2 Emergencies Seen in the Ambulatory Setting
9:30-10:30 a.m. — Overlook Hospital, Summit
(Sponsored by Departments of Family Practice and Community Medicine and AAFP)

- 2 Survey of Allergy-Immunology
9 11 a.m. — St. Elizabeth Hospital, Elizabeth
16 *(Sponsored by Elizabeth Tri-Hospital Residency Program and AAFP)*

- 3 Pathology as It Relates to Medical Conditions
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)

- 3 Review of Internal Medicine
10 Sheraton Inn, Newark Airport, Elizabeth
(Sponsored by Academy of Medicine and CMDNJ-New Jersey Medical School)

- 3 Psychiatric Aspects of Criminology

- 17 Part I and Part II
3:00-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)

- 3 Can you Treat Depression?

- 10 Application of Acupuncture in Medical Practice

- 17 Recent Trends in Genetics
9:00-11:00 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

- 11 Management of Venereal Diseases
6:30 p.m. — Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)

- 15 Clinical Aspects of Colonic Cancer
12:00-1:00 p.m., Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)

- 17 Acute Abdominal Trauma and Peritoneal Lavage as Diagnostic Tool
1:00 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)

OBITUARIES

Dr. Peter R. Bonafide

At the very onset of his career Peter R. Bonafide, M.D., just elected to the Middlesex County Medical Society in June of this year, died on July 2, 1975. Born in New York City in 1944, Dr. Bonafide received his undergraduate education at Georgetown University and his medical degree from Jefferson Medical College in 1969. Following internship in Hartford, Connecticut, he completed a three-year residency in obstetrics and gynecology at Yale-New Haven Medical Center and came to Milltown in July 1973 to pursue a practice in that specialty. He was 30 years old at the time of his death. Dr. Bonafide was a member of the American Fertility Society.

Dr. Clarence A. Bowersox

Clarence A. Bowersox, M.D., a member of our Gloucester County component, died on May 3, 1975, after a long illness. Born in 1903 and a

graduate of Jefferson Medical College in 1928, Dr. Bowersox practiced cardiology in Woodbury for many years before retiring in 1966. He had taken his graduate studies at Tufts Medical College and New York Post Graduate Medical Center. He was a member of the attending staff at the Underwood Hospital and had been secretary of his County Medical Society. Dr. Bowersox was active in civic affairs and had been Gloucester County Coroner. He was a Fellow of the American College of Chest Physicians.

Dr. George W. Caldwell

On June 18, 1975, George W. Caldwell, M.D., formerly of Tenaflly, died suddenly in Florida. An Emeritus Member of this Society, Dr. Caldwell had retired from active practice in 1969 and moved to Boca Raton, Florida. He received his doctorate of medicine in 1924 from the Medical College of the University of Vermont and took his graduate work in pediatrics at New York Post Graduate University. He was certified by the American Board of Pediatrics and was a Fellow of the American Academy of Pediatrics. Dr. Caldwell had been on the active

staff at Bergen Pines Hospital in Paramus and at the Englewood Hospital. He was 77 years old at the time of his death.

Dr. Jose L. DelRio

Word has been received of the death of Jose L. DelRio, M.D., a member of the Essex County Medical Society, on May 24, 1975 at St. Barnabas Medical Center, Livingston. Born in 1910 and a native of Cuba, Dr. DelRio was graduated from the University of Havana Medical School in 1938 and practiced internal medicine there until he came to New Jersey in 1963. His office was located in Bloomfield and he was affiliated with the Clara Maass Memorial Hospital in Belleville.

Dr. John J. Federer

One of Hudson County's senior practitioners, John J. Federer, M.D., died on May 5, 1975 after a prolonged illness. A graduate of Boston University College of Medicine in 1932, Dr. Federer practiced general medicine, with special interest in diabetes, in Weehawken for most of his professional career. He was a Fellow of the American Academy of Family Practice, and a member of the American Geriatrics Society, the New Jersey Diabetes Association, and the Academy of Medicine of New Jersey. He had been chief of medicine at St. Mary's Hospital in Hoboken.

Dr. John S. Forbes

John S. Forbes, M.D., a general practitioner of the "old school" who served the people of Basking Ridge for many years, died suddenly on June 19, 1975 at the age of 70. A native of Glasgow, Scotland, Dr. Forbes was graduated from Duke University Medical School in 1934. He was chief of the general practice section of the Morristown Memorial Hospital and a member of the associate staff at All Souls Hospital in Morristown. He was a member of the American Academy of Family Practice and during World War II served in the Medical Department of the United States Army with the rank of Captain.

Dr. Sidney Gehl

On June 6, 1975, Sidney M. Gehl, M.D., a member of our Essex County component, died

suddenly at St. Barnabas Medical Center in Livingston. Born in 1913 and a graduate of Jefferson Medical College, class of 1938, Dr. Gehl did graduate work in endocrinology at New York Medical College and devoted his practice to that specialty. He was associated with the Beth Israel Hospital in Newark.

Dr. Gerard R. Gessner

Word has been received of the death, on June 23, 1975, in Maryland, of Gerard R. Gessner, M.D., a member of our Middlesex County Medical Society. Dr. Gessner was graduated from Georgetown University Medical College in 1934 and after completing a residency in obstetrics and gynecology established a practice in Highland Park. He served five years with the medical department of the United States Army during World War II, and returned to New Jersey to re-establish his practice in New Brunswick. Dr. Gessner was a Fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecology, and had been chief of the department of obstetrics and gynecology at St. Peter's Hospital and senior attending in that department at Middlesex General. In 1967, a physical condition forced his retirement from active practice and he accepted an appointment with the Food and Drug Administration in Washington, D.C., and also one as clinical instructor in obstetrics and gynecology at the Georgetown University Medical Center. Dr. Gessner was a past-president of the Middlesex County Medical Society. He was 65 years old at the time of his death and resided in Rockville, Maryland.

Dr. Henry Z. Goldstein

The former assistant medical director at Newark Beth Israel Hospital, Henry Z. Goldstein, M.D., died suddenly there on June 1, 1975. A graduate of the University of Pennsylvania College of Medicine in 1926, Dr. Goldstein took residencies in otolaryngology at Mt. Sinai Hospital in New York and at the Universities of Vienna and Bordeaux before establishing a practice in Newark. He was board certified in his chosen specialty and was a Fellow of the American Academy of Ophthalmology and Otolaryngology. He was a member of the Academy of Facial Plastic and Reconstructive

Surgery, the American Association of Ophthalmology and Otolaryngology, and the Academy of Medicine of New Jersey. Before retirement from active practice, Dr. Goldstein had been affiliated also with St. Michael's and the Eye and Ear Infirmary in Newark, and with the West Hudson Hospital in Kearny.

Dr. Harry Greene

One of Hudson County's senior practitioners, Harry Greene, M.D., died on July 14, 1975, after a long illness. Born in 1907, in Roumania, he received his medical degree from New York University School of Medicine in 1933. His practice was limited to urology and he was associated in that department at the Christ and Fairmount Hospitals in Jersey City. During World War II Dr. Greene was a Major in the medical department of the Army of the United States.

Dr. Wladimir Huk

At the untimely age of 55, Wladimir Huk, M.D., died suddenly on July 24, 1975. Born in Poland and educated in Vienna, Dr. Huk received his medical degree from the University of Vienna in 1946. He came to the United States in 1948 for internship, followed by a general residency at St. Mary's Hospital in Orange. His offices were located in Newark and he was senior attending on the general medical staff at East Orange General Hospital, and was on the courtesy staffs at the Community Hospital in Montclair and St. Barnabas Medical Center in Livingston.

Dr. John H. Irwin

Word has been received of the death, on June 19, 1975, following a prolonged illness, of John H. Irwin, M.D., a senior member of our Bergen County component. Born in 1898, and a graduate of New York University School of Medicine in 1922, Dr. Irwin practiced surgery in Englewood until the early 1960's when he retired from active practice and accepted an administrative position with the Joint Commission on Accreditation of Hospitals. He was a Fellow of the American College of Surgeons and had been on the surgical staff at the Englewood Hospital. Dr. Irwin had a term each as President

and Treasurer of his County Medical Society (Bergen), and was active in civic affairs, having been Englewood Police Surgeon for 20 years and a member of the Englewood Board of Health, serving as its president for a three-year term. During World War II, he was a medical officer in the United States Navy.

Dr. Max M. Jarecki

On June 17, 1975, Max M. Jarecki, M.D., died at Jersey Shore Medical Center after a long illness. A graduate of the University of Heidelberg Medical College in 1913. Dr. Jarecki came to New Jersey in 1938 and practiced dermatology in the Asbury Park area for many years. He had been born in Posen, Germany, and was 86 years old at the time of his death. Dr. Jarecki was a member of our Monmouth County Medical Society.

Dr. Edd Jones

Word has been received of the death on May 20, 1975, of Edd Jones, M.D., a general practitioner from Orange, and a member of our Essex County Medical Society. Dr. Jones received his doctorate of medicine from Howard University Medical School in 1935 and returned to New Jersey to practice there for all of his professional career. He was 71 years old at the time of his death.

Dr. Robert Kollmar

Robert Kollmar, M.D., a member of our Essex County component, died on May 15, 1975, while vacationing in Miami. Born in 1920 and a 1943 graduate of Columbia University College of Physicians and Surgeons, where he also completed a three-year residency, Dr. Kollmar practiced urology in Short Hills. He was a diplomate of the American Board of Urology and a Fellow of the American College of Surgeons. He was affiliated with St. Barnabas Medical Center in Livingston, the Overlook Hospital in Summit, and Orange Memorial Hospital. Dr. Kollmar was a member of the American Urological Association and had served a term as secretary of the urological section of the Academy of Medicine of New Jersey. During World War II, he served with the United States Army Medical Department in Germany.

Dr. Vito A. Lamberto

Vito A. Lamberto, M.D., who was a general practitioner in Lyndhurst, died on May 29, 1975, after a long illness. A 1932 graduate of the University of St. Louis College of Medicine, Dr. Lamberto pursued graduate work in anesthesia, and in addition to his general practice, was senior attending anesthesiologist at the Passaic General Hospital. He was a Fellow of the American College of Anesthesiology and a member of the American Society of Anesthesiologists and of the Essex County Anatomical and Pathological Society.

Dr. Clifford H. Nelson

A former member of the Essex County Medical Society, recently transferred to the Ocean County component, Clifford H. Nelson, M.D., died on May 29, 1975. Born in Newark in 1919 and a graduate of New York University College of Medicine in 1944, Dr. Nelson was a general practitioner of medicine and surgery in Irvington for many years, and was on the surgical staff at the Irvington General Hospital. In 1972 he retired from active practice and moved to Waretown. He was a member of the emergency room staff at the Community Memorial Hospital in Toms River. Dr. Nelson was a member of the Academy of Medicine of New Jersey and had been active in civic affairs in Essex County where he served as school physician in his home community of Irvington. During World War II, Dr. Nelson served with the medical department of the Army of the United States, with the rank of captain.

Dr. Richard H. O'Connor

Word has been received of the death on May 24, 1975, of Richard H. O'Connor, M.D., a general practitioner, who was a member of our Bergen County component. A native of New York State, Dr. O'Connor was graduated from the Medical College of New York University, class of 1951, came to Paterson for internship, and immediately upon completion opened offices in Glen Rock where he continued to practice to the present. He was affiliated with the Paterson General Hospital and Valley Hospital in Ridgewood, and was school physician for his home community. Dr. O'Connor was in the 60th year of his age.

Dr. Albert J. Sekerak

One of Mercer County's senior practitioners, Albert J. Sekerak, M.D., died on July 10, 1975, at St. Francis Medical Center, Trenton. Born in New York City in 1902, Dr. Sekerak was a graduate of Jefferson Medical College, class of 1928. He pursued a residency at Brooklyn Eye and Ear Hospital and graduate studies in otolaryngology at Columbia University and the University of Illinois, and his practice was limited to that field. Dr. Sekerak had been on the associate staff of that department at the St. Francis Medical Center in Trenton. He was a member of the American Academy of Ophthalmology and Otolaryngology.

Dr. Murray Shulman

Chief of hematology services at the United Hospitals of Newark, Murray Shulman, M.D., died in Monmouth Medical Center, Long Branch, on June 3, 1975, after a coronary attack en route home from the MSNJ annual meeting in Cherry Hill. A graduate of Johns Hopkins Medical School in 1934, Dr. Shulman joined the staff of United Hospitals of Newark in 1937, where he was also director of the blood bank. He was Assistant Clinical Professor of Pathology at the New Jersey Medical School, CMDNJ, and was affiliated in the hematology and pathology departments at Martland, Children's, and Presbyterian Hospitals in Newark. He was a diplomate in pathology, both anatomical and pathological, and was a Fellow of the American College of Pathologists. Previously he had also been associated with Montclair Community Hospital, Irvington General Hospital, and the Veterans Administration facility at Newark. Dr. Shulman is a past-president of the Academy of Medicine of New Jersey.

Dr. William J. Snyder

William J. Snyder, M.D., formerly a practicing surgeon with offices in Weehawken, who retired about ten years ago to Sparta, died on June 7, 1975, after a prolonged illness. Born in 1887 in New York City, Dr. Snyder earned his medical degree from New York Medical College in 1917. He had been senior attending surgeon at the North Hudson Hospital in Weehawken and was a member of the Hudson County Medical Society.

BOOK REVIEWS

Heroin Addiction in Britain: What Americans Can Learn from the English Experience. Horace Freeland Judson. New York, Horcourt Brace Javanavich, 1974. Pp. 200 (\$6.95)

Mr. Judson, an American journalist, has given us a highly readable and informative account of the history of heroin addiction in England. In addition it challenges some commonly held beliefs about drug experience, withdrawal syndrome, relationship of addiction and crime, and so on. His report summarizes and integrates the experience of many workers in the United Kingdom and the United States.

Mr. Judson documents the fact that heroin addiction in England is under control, a conclusion shared by other British workers in a recent commentary in the JAMA.¹

In the early sixties treatment of heroin and related addiction shifted from private practitioners to clinics, where the staff is allowed to provide maintenance treatment with heroin and other opiates. As the report unfolds it becomes clear that the active therapeutic ingredient is not the maintenance treatment in itself but the relationship of the addict to his doctor and the clinic. The clinic setting is equally supportive to the doctors, relieving the emotional strain of working with addicts by group sharing and group supervision.

Addiction is not just a problem of the individual, but also a response of the individual to his society and of the society to the addict. Addiction results from an interplay of individual and social factors in a specific cultural setting. An effective approach to addiction has to incorporate all these dimensions. In our country the addict arouses much more anxiety than in England. Our vast illegal drug distribution system is typical for the United States. Such factors underlie our predominantly legal approach while the English approach arose out of a medical model of treatment.

Acknowledging the differences between American and British society and the existence of subcultures within the United States, it must be clear that we cannot just transfer the English experience to the American scene. The contribution of Mr. Judson's study is that it guides us in asking the right questions in our search for effective treatment.

Neuropsychiatry in World War II, Volume II, Overseas Theaters. Medical Department of the United States Army. Superintendent of Documents, United States Government Printing Office, Washington, 1973. Pp 1140. (\$16.20)

This volume should be brought to the attention of every dean of curriculum of every medical school in the country. It serves as a written testimonial not only to the men who accomplished so much in the face of adversity but also as a testament to the human tendency to repress and obliterate the lessons of psychiatric experience in the human equation. The moral teaching from this work, duly appreciated, would

undergird the economic wisdom of initiating the medical school curriculum with one year of comprehensive training in psychiatry preliminary to training in the technical specialties. This would, perhaps, lead the profession away from its recent emphasis upon biological showmanship and the heroic prolongation of dying in the face of inevitable death to the importance of the emotional and social aspects of illness.

The following trends are gleaned by way of example. At the outset of World War II it was felt that the psychiatrically unfit could be screened from the army by brief questionnaire-type interviews resulting in a psychiatrically hygienic army. Little provision was made to distinguish incapacitating from non-incapacitating psychiatric disorders. There was a tendency to reject all. In the South West Pacific Area during 1942 and 1943 a soldier might be hospitalized for two or three months with an organic diagnosis before he was recognized as neurotic and given appropriate treatment. Great strides forward to return to service were made by establishing advance based facilities for short term psychiatric care with as high as 88 percent return to active duty.

The psychotic patients who represented a 4 to 5 percent incidence posed unbelievable problems for transportation alone. There usually were provisions in general hospitals for these cases, but during the entire South Pacific campaign not one electro-shock machine was made available in the entire operation. Emotional factors in endemic disease control were high-lighted in the atabrine malaria control program. The incidence of malaria was 4,000 to 1,000 at times. Such attack rates meant terrific loss of manpower. When the taking of medication in hospitals was more strictly supervised, patients invariably recovered from tertian malaria. This whole matter was of interest to psychiatrists because the same basic drive to be relieved of duty and returned to the United States or, at least, transferred to an organization in Australia was at work in the neurotic complainer. It provided a reliable forecast of what could be expected if a "soft policy" of hospitalizing neurotic-type complainers was followed. From another view point it was easier to move 100 wounded than 10 psychotic. Nevertheless the apparent psychogenic aspects of atabrine never could be satisfactorily evaluated because this suspected source of psychoses had to be kept secret for morale reasons and because of possible political effects.

Ira S. Ross, M.D.

Handbook of Microbiology. Condensed Edition. Laskin and Lechevalier. Cleveland, CRC Press, 1974. Pp. 930. Illustrated (\$14.95)

This is an abbreviated version of the comprehensive four-volume CRC "Handbook of Microbiology" which presents selected material of interest to a wider audience. It is a soft-bound volume within the reach of students, research assistants, teachers, and others who would not have a need for the larger set. In reality, only material from Volumes I, II and IV of the "Handbook of Microbiology" is presented; the material in Volume III which deals with microbial products does not lend itself to this kind of selection.

Included within the condensed version are the properties of the major bacterial groups, the fungi, algae, protozoa, and viruses. Also included is some useful information in selected biochemical properties of amino acids, lipids, as well as basic information on metabolism, genetics, and immunology. This condensed version should be found in every microbiological laboratory.

A. Arthur Gottlieb, M.D.

¹Blumberg H H, et al: Opiate use in London. *JAMA* 232:1131-1132, 1975.

A. Johan Noordsij, M. D.

Handbook of Pediatrics. H. K. Silver, C. H. Kempe, and H. B. Bruyn. Los Altos, California, Lange, 1975. Pp. 705 (\$7.50 softback)

Here is a tremendous amount of information packed into 676 pocket-size pages. More data, a six inch rule and a fifteen centimeter rule are added inside the covers.

Essentially this eleventh edition is published for students and housestaff. However, the practicing primary physician who cares for children will find this book useful. If you are secure enough to look up information while patients and parents are in the office, this is a handy book to keep on your desk.

There are a few suggestions I could make for the next edition. Under drug dosages for digitalis we are referred to table 13-4. It would be better to be referred to page 230. I don't know how helpful it is to be told that undescended testes may descend if the child is examined in a hot tub. I wonder if the univalent Sabin oral polio vaccine is really superior to the trivalent vaccine as is implied on page 101. The philosophical approach in some areas is conservative to the extreme. The use of medication in the MBD syndrome is not mentioned, although it is considered in the section on hyperactivity. Happily the authors deplore most tonsillectomies and adenoidectomies.

I recommend this book for students, house staff, and the practicing pediatrician; the size and the price are just right.
Solomon J. Cohen, M.D.

Emergency Department Organization and Management. American College of Emergency Physicians, A. L. Jenkins, M.D. Editor. St. Louis, Mosby, 1975. Pp. 257. (\$14.50)

This book has been a long time in coming, but as in every new field of endeavor, experiences and difficulties must be entertained before final results come through. Up to now there has been a flurry of books on emergency services and management without a thorough in-depth study. This one is the result of several years of experience by its many contributors and the best minds in emergency medicine. No other group of individuals could have pursued this field than those who are actively engaged in emergency medicine. Every facet of emergency medicine is adequately and descriptively covered, such as, administrative, clinical, financial, legal, and governmental. A most important area is the section entitled — areas of significance in emergency medicine — which classifies the disorders encountered, the conditions in area of classification, and the required skills necessary. The book is well written and easily understandable. It should be in every hospital administrator's office, medical school library, and used by every emergency department physician.

Jack R. Karel, M.D.

Genetic Screening. Programs, Principles, and Research. Committee for Study of Inborn Errors of Metabolism, National Research Council. Washington, DC, National Academy of Sciences, 1975. Pp. 388.

The preface to this excellent and timely book starts with the following paragraph: "The Committee hopes that the report will be read with profit by all persons concerned with teaching preventive medicine or engaged in its practice. The audience we hope to reach includes health professionals in various disciplines and interested consumers, as well as the many other persons engaged in work related to the preserva-

tion of health, such as economists and other social scientists, lawyers, educators, and policymakers." This book will make profitable reading for all *physicians* inasmuch as screening programs of one kind or another will involve their professional lives at some time during the coming decade, regardless of their specialty.

The rapid proliferation of screening programs coupled with recent advances in genetics, the changes in disease patterns and the emphasis on preventive medicine, and the mistakes in various screening programs that have been made in the past have made mandatory the Committee's review of current screening practices and their shortcomings in order to give procedural guidance for more effective future screening programs.

After introductory chapters, there is a review of the history of screening for phenylketonuria in the United States, and the lessons derived from such testing; a survey of screening for a variety of other genetically determined diseases; discussion of genetic registries and family screening; a review of the principles of health behaviour and the attitudes toward screening expressed by physicians and consumers; discussion of legal, ethical and economic principles with suggestions for future research; procedural guidance for health authorities planning new screening programs; and final appendices and statements by various specialty groups. On page 267, there is a figure outlining the procedure for evaluating proposed genetic screening programs, which indicates the many facets that are involved. The figure begins with the evidence of public need for such screening and state of public preparedness and evolves down to the actual screening. All these aspects are covered in detail in the preceding chapters. Particular attention should be paid to the discussion of the population which is to be screened as it relates to age, ethnic and geographic limitations.

On page 162, there was a fascinating bit of information concerning "physicians' knowledge about genetics." More than half the sample of physicians believed that sickle cell trait causes occasional or frequent medical problems. This lack of *medical* — not genetic — knowledge indicates that the admonition of "Physician, Heal Thyself!" should be applied to the extent that all physicians read this book and become capable of making rational and unemotional decisions with regard to proposed future screening programs.

Theodore Kushnick, M.D.

Medicaid: Lessons for National Health Insurance. A. D. Spiegel and S. Padoir, Editors. Rockville, Morylond, Aspen, 1975. Pp. 361. (\$24)

This is a reference volume for those physicians, administrators, legislators, and students who are concerned with the history, development, assessment, and impact of current legislated health programs, particularly as they relate to the anticipated future institution of nationalized health care and the correction of previous errors. This volume has some value; however, it is a compilation of articles previously printed in a wide range of publications ranging from the popular press to esoteric journals by an equally wide range of authors varying from reporters to established experts. Thus, the style and even the print varies in each article, which makes for difficult reading. A well conceived theme for a doctoral thesis, the candidates' research file has been published in this volume apparently before the authors got around to writing their own thesis. Conclusions, primarily negative by virtue of selection, are left for the reader to make.

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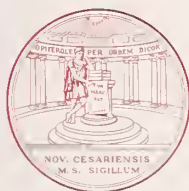
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Hydrochlorothiazide to help keep
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to help keep potassium levels up.

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complication or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that frightened by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it could depend on the medication in question. For example, in the case of an injectable long-acting progestrone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could reserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

only the doctor can remove that fear of 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him at a concerned medical decision has made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

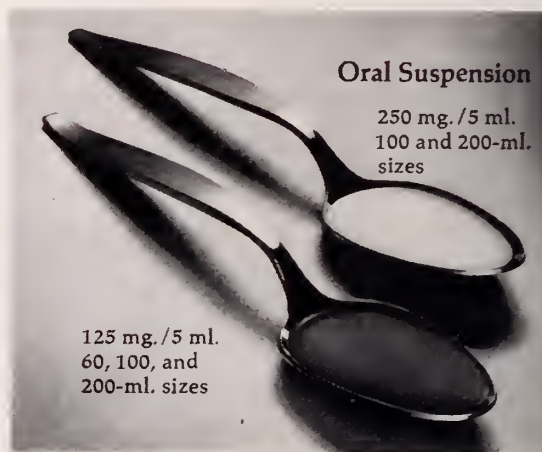
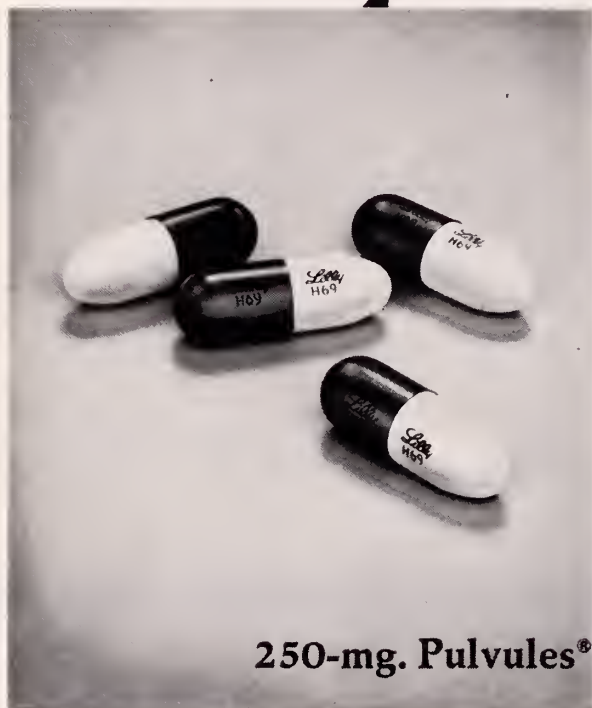
I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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EDITORIALS

Medicaid Payments

The announced decision to reduce Medicaid payments to physicians by ten percent is a cruel hoax upon the Medicaid patient, the physician, and every taxpayer in this state. Payments which were already ludicrously low, and which had risen only five percent since the beginning of the Medicaid program, are now being reduced to a level five and a half percent lower than they were in 1970. In the meantime, the physician's expense for malpractice insurance has soared, while expenses for rent, salary, telephone, and supplies have also moved upward.

Prior Medicaid practices, designed to prevent abuse of the system by a few, have resulted in a situation geared to the actions of the "bad apple" rather than the bunch. These restrictions have made it difficult to render first-class care to Medicaid recipients, and have caused many conscientious and competent physicians to refuse to see these patients, who are left in the hands of those willing to run a high-volume, rapid-turn-over, impersonal practice, where the fixed costs could be spread over thousands of patients, rather than hundreds, and where the restrictions placed in the path of proper treatment were not so readily felt.

No politician, Ann Klein included, has been asked to return to 1970 salaries. The doctor, however, is a ready and visible target, supposedly prosperous, and immune from arbitrary cut-backs in his fees. When there is a protest, the finger is pointed at those few who have abused the system.

The time has come for us to point the finger. The facts must be made known to the public. The facts must be brought home to the State Legislature. These same people, who are anxious to divert health care monies to the practitioners of chiropractic and other cults, must be made to feel the grievous responsibility for what they are doing. They must be put in the public spotlight

as the villains in this sorry melodrama. We must, as an organized society, mobilize the goodwill and talent which is at our disposal to bring the true story to the public.

The fact is this action will result in even fewer doctors accepting Medicaid patients, as it becomes financially prohibitive to do so. The fact is that these patients will then be forced to seek treatment in clinics and emergency rooms where the cost is three to four times more than it is in a doctor's office.

The fact is more physicians will be encouraged to move out of the central cities, leaving them "medical wastelands."

The fact is more money will be required from the State, and therefore from every taxpayer, to support these higher costs of hospital out-patient care.

The fact is the State has provided greater inducement to shorten the time a physician spends with his patient and this can only mean a lowering of quality of medical care.

The fact is some State officials are not concerned about "quality" care. Our hospital administrators have a tape recording of such a State official who, at a budget hearing in which the hospitals were trying to justify the need for trained personnel, including registered nurses, stated that he did not want to hear about quality care because what the State was concerned about was cost. If that is the policy of the Legislature, then that fact should be brought to the attention of the public because that is not an accurate reflection of what the people expect when they seek medical care.

This attack upon an established fee system, even though it was already woefully inadequate, is a dangerous first step which should not go unanswered. The next reduction might be twenty percent, and the next agency might be Medicare. After that, we may find a fixed-fee schedule imposed upon us. The time to act is now.

Robert A. Goldstone, M.D.

Closure of Glen Gardner

Unfortunately, tuberculosis remains a major health problem for the State of New Jersey. In 1974 New Jersey ranked 22nd among all states in terms of case rates, but 8th when total incidence is considered. Tuberculosis is mainly an urban disease. Nationally, in 1973, Newark ranked first among the 58 cities of 250,000 or more population as to new active case rates, Jersey City ranked 15th, and among the 95 cities of 100,000 to 250,000 population, Paterson ranked second, Trenton sixth, Camden 29th, and Elizabeth 37th. Atlantic City is first in cities below 100,000 population.

A year ago, Commissioner Ann Klein of the Department of Institutions and Agencies and her staff were concerned about the fact that New Jersey was a major state with a categorical tuberculosis facility. She wondered about the utility of such a program in an era when tuberculosis was widely being brought back into the mainstream of medicine and medical care. She was also concerned about the use of 3.3 million dollars in state tax levy that perhaps might be better spent elsewhere.

At the time of her concerns, some of us felt that the existence of Glen Gardner, as a convenient dumping ground for undesirable patients, actually kept the state from facing its responsibility to develop a meaningful program for out-patient tuberculosis management. We believed the time had come for general hospitals to accept their rightful responsibility to their communities, to hospitalize tuberculosis patients, some of whom are alcoholic or unkempt, rather than dislocate them to Glen Gardner.

A Task Force (see report, page 845, this issue) of representatives of the New Jersey medical community, as well as internationally known experts in public health and tuberculosis, was established. It had staff support from concerned voluntary and governmental sectors. We reviewed the Glen Gardner situation and interviewed all the patients at the facility late in October 1974. We found, to our dismay, that most of these patients could and should be cared for elsewhere, mainly as out-patients, if adequate

facilities existed. The Task Force unanimously recommended:

That Glen Gardner be closed as soon as possible;

That the State Health Department's Tuberculosis Control Program be revised and upgraded;

That general hospitals and long-term care facilities be required to provide in-patient care for tuberculosis patients;

That ambulatory care services be initiated, augmented, and upgraded;

That an adequate program of state financial aid be adopted;

That 1.3 million dollars be switched from the Glen Gardner budget to health departments to provide the program with state financial aid;

That an evaluation committee be appointed to oversee the transition; and

That concerned educational efforts be carried out.

No longer is a study group saying "develop services and then close Glen Gardner." No longer is such a group saying "keep Glen Gardner." The closing of Glen Gardner, the Task Force feels, will not only provide resources for revising and upgrading tuberculosis control, but will force the health care delivery system in New Jersey to accept and treat tuberculosis as any other medical condition, not as an exotic special disease.

We know that the Task Force report won't answer all the questions that are sure to arise. It may well create some problems. Change always does. Services develop, however, when there is a need and, when tuberculosis patients need to be hospitalized and there is no Glen Gardner, local hospitals will have to care for them. A similar situation in New York involved the Seaview Hospital on Staten Island. At this institution, which had a most illustrious tuberculosis tradition, Doctors Selikoff and Robitzek first used isoniazid in the early 1950's. When only three patients remained in the institution, my staff and I went out to each of the local Staten Island hospitals to try to convince them to care for tuberculosis patients. We scheduled formal meetings with administrators, medical board, chairmen of infection committees, and nursing personnel. The hospitals all surprised us by saying, "There won't be any problem, we already take tuberculosis patients. We fulfill our responsibility to our community."

The message of our Task Force is that the medical profession, in its hospitals, clinics, and private offices, must respond to the local needs of the community in 1975. There is no valid medical or non-medical reason why tuberculosis should be separated from the rest of medical care with segregated hospitals and clinics. If a need for care for tuberculosis patients exists, then the local community must fulfill that need. With the existence of Glen Gardner there has been no motivation to do this. The lack of Glen Gardner, coupled with the financial incentive as evaluated by the Task Force, will clearly provide such motivation. The closing of Glen Gardner will be a major factor in bringing tuberculosis care and control back into the mainstream of medicine in New Jersey. L. B. Reichman, M.D.

A Word to the Wise

Manuscripts dealing with the results of a treatment, an operation, or a procedure often contain evaluatory tabular material, which is subjective at best. Every author is always hard-put to find a scale on which results may be weighed in order to convey his opinion to the reader. It is difficult — perhaps impossible — to be completely unbiased, especially about a technique which was conceived, nurtured, and delivered through one's own efforts. This maternal depiction was not idly chosen; what mother believes her newborn child to be anything but beautiful?

In a paper which was recently studied, a surgeon described the results of his operations something like the following: excellent — 36%, good — 19%, fair — 31%, poor — 14%

Being uncertain of the meaning of those adjectives, in relation to the operation, I turned to a popular and useful wordbook and found the following:

Poor: inferior, indifferent, trivial, meager, inadequate, scant, deficient, sorry, beggarly, shabby, contemptible, scrubby, shoddy, defective, unworthy, worthless, tawdry, trashy, base, second-rate.

Fair: pretty good, not bad, middling, average, medium, ordinary, moderately satisfactory, not amiss, passable, tolerable, reasonably good, respectable, decent, so-so, above mediocrity, indifferent, run-of-the-mill.

Good: satisfactory in quality, meritorious, commendable, genuine, sterling, sound, admirable, valuable, excellent, capital, choice, first-rate, first-class, crack, top-hole, tiptop, superfine, select, best, golden, gilt-edged, priceless.

Excellent: superior, transcendent, of the highest order, of great worth, sterling, first-class, first-rate, fine, choice, prime, tiptop, admirable, of the first grade, of the highest quality, topnotch, matchless, perfect, superfine, A-1, superlative, pre-eminent, capital, exemplary.

I noticed, among other things, that the editors of the thesaurus found it difficult to differentiate between good and excellent and repeated themselves — sterling, first-rate, tiptop, and superfine. Furthermore, they may have been unhappy with the gold standard (or perhaps the price of gold shares) for golden is good while sterling (which often refers to silver) is both good and excellent.

Exercising an editor's prerogative, I played around with the table and came up with a couple of modifications:

Topnotch 36%	Superlative 36%
Tiptop 19%	First-rate 19%
So-so 31%	Not bad 31%
Worthless 14%	Contemptible 14%

These worried me, because the top two categories seemed immodest and, in these days of medical-legal difficulties and malpractice insurance premiums which threaten to dwarf Mt. Everest, I did not believe a surgeon would appreciate his operation being considered worthless, contemptible, or not bad.

What to do? It is the responsibility of the author to confess that such results are his value judgments. If they cannot be reduced to objective, reproducible, replicable definitions, a narrative description of what the author considers "excellent," "good," "fair," or "poor" is the least the reader deserves.

For example, "excellent" means "restored to full function without pain or other symptoms and able to fulfill all occupation, family, and social commitments." "Poor" means "the patient retained most or all of his complaints and disability — or got worse — despite the procedure."

How many "excellent" procedures over the past 50 years have ultimately been discarded as "worthless?"
A.K.

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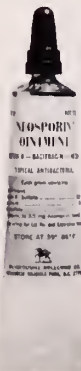
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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Putting out the fires of arthritic pain

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If aspirin fails, consider Butazolidin alka. Giving one capsule four times a day often provides prompt, pain-relieving, anti-inflammatory action to help restore joint mobility. The results you can get within a week can be maintained on as little as one or two capsules daily.

Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions. For full details, please read the prescribing information. It's summarized on the back of this page.

Butazolidin[®] alka

Each capsule contains:
100 mg. phenylbutazone USP
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If it doesn't work in a week, forget it.



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Butazolidin® alka

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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia, history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema, stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpre-

dictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dys-

pepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

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Stereotactic transnasal cryohypophysectomy has become an accepted method for pituitary ablation. Fifteen patients have been operated by this technique for acromegaly, metastatic carcinoma of the breast, prostate, and diabetic retinopathy. The procedure is relatively benign and is well tolerated by seriously ill patients. The mortality and morbidity are low and the results are immediate especially for the relief of pain.

Stereotactic Transnasal Cryohypophysectomy

A Preliminary Report

**Yashwant Bhandari, M.D.,
Stanley Stellar, M.D., and
Richard Fogel, M.D./Livingston***

Introduction

The ability to perform a hypophysectomy with low morbidity and mortality has, in part, determined its clinical use. It is generally employed as palliative therapy, especially in metastatic carcinoma of the breast, prostatic carcinoma and diabetic retinopathy. Stereotactic transnasal transphenoidal cryohypophysectomy, which offers these advantages, is becoming an acceptable method of pituitary ablation. This procedure is ideally suited for normal pituitary gland and/or certain intrasellar tumors.

We have utilized this technique in 15 cases in the past two years and are reporting our preliminary results.

Method

We performed stereotactic transnasal hypophysectomy in 15 patients using Todd-Wells apparatus† and have obtained some pituitary gland biopsies before and after cryodestruction. Polypeptide hormones, mainly growth hormone, adrenocorticotrophic hormone, prolactin and thyroid stimulating hormone are determined by radio-immunoassay prior to surgery, during freezing, during thawing and two, four and twelve hours and six weeks after surgery. Such hormone estimations before, during and after surgery may serve as a good criterion of the completeness of the hypophysectomy.

The Procedure

The procedure is done under general or topical anesthesia with the patient's head aligned in the stereotactic frame and bony fixation provided by four screws on the frame. The horizontal plane is collimated using the image intensifier, the image being projected on the screen. The head holder is then adjusted to bring the guide line of the apparatus over the middle of the sella turcica as seen in the anteroposterior view. In the lateral view, the lower anterior quadrant of the sella turcica is brought into the transverse axis of the arc. Once these adjustments are made, the probe directed from any point on the arc will reach the sella turcica. Nevertheless, this is confirmed by check radiographs.

The nose is packed with a tape soaked in phenylephrine hydrochloride (Neosynephrine®), Bacitracin solution for 10 minutes and then removed. The cryoprobe guide is passed through the nostril by gentle twisting movements and hammer. The floor of the sella turcica is perforated by a twist drill. A 3.2cm Linde cryoprobe is then inserted into the pituitary gland. Anteroposterior and lateral x-rays are taken to confirm the exact position of the probe and for the record. (Figures 1, 2) At this time, the patient is awakened and cooling of the probe is started by circulation of liquid nitrogen from

*This work is from the Division of Neurological Surgery and the Endocrinology Department of St. Barnabas Medical Center, Livingston.

†Made by Trent H. Wells, Jr. Mechanical Development Co., Southgate, California 90280.



Figure 1 — Anteroposterior x-ray view showing bony fixation and cryogenic probe passed transnasally into pituitary fossa. Note alignment of the radio-opaque line on the frame with the midline of the skull.

the cryogenic unit. As the cooling advances, function of the optic, oculomotor, trochlear and abducent nerves are tested every few seconds. If any dysfunction is observed, the cryosystem unit is shut off immediately. The incipient palsy disappears rapidly. Two lesions are made, the first at -196°C for 10 minutes and the probe is then warmed. After five minutes, another lesion is made at the same place at -196°C for 10 minutes. At the end of the procedure, the defect in the floor of the sella turcica is sealed by a silastic plug with a silver marker. (Figure 3) The nose is packed with Bacitracin-Neosynephrine[®] pack for 48 hours. Steroids and antibiotics are administered pre- and post-operatively. The patient is kept flat in bed for five to seven days to ensure healing and to prevent spinal fluid leakage.

Results

Fifteen patients have had stereotactic cryohypophysectomies during the past two years. Four were treated for acromegaly, five for metastatic breast cancer, two for metastatic car-



Figure 2 — Lateral x-ray view showing alignment of the cross and circle over the sella turcica. The cryogenic probe is in place.



Figure 3 — Lateral view of skull showing closure of bony defect in floor of sella turcica by means of a silastic plug marked by a silver clip.

cinoma of the prostate, two for pituitary adenoma and two for severe diabetic retinopathy. (Table)

The results of pituitary ablation were recorded as subjective and objective. A subjective response was recorded when the patient experienced a definite relief from pain, correction or improvement of anemia, gain in weight and appetite and overall general improvement. A

result was objectively judged as good when there was decrease in the size of the primary or metastatic lesion measured directly on roentgenograms, by disappearance of neurological deficit, by improvement or increase in function of an organ and decrease in the growth hormone, serum acid phosphatase levels, and so on.

Acromegalic patients, all of whom had radiotherapy in the past, have done well. Growth

Table
Results of Transnasal Cryohypophysectomy

<i>Age Sex</i>	<i>Diagnosis</i>	<i>Previous Treatment</i>	<i>Complaints Lab Data</i>	<i>Re Subj</i>	<i>Obj</i>	<i>Survival</i>	<i>Complications & Comments</i>
61 M	Acromegaly	Cobalt	Low back and hip pain; † GH*	+	+	Alive two years	0
23 M	Acromegaly		Shoulder pain, body growth; † GH	+	+	Alive over one year three months	0
57 M	Acromegaly	Cobalt	Increased weakness; coarse features; † GH	+	+	Alive 4 months	Biopsy showed eosinophilic tumor
63 F	Acromegaly	Cobalt	† GH	+	+	Alive 3 months	0
32 F	Chromophobe adenoma	Cobalt	Headache	+	+	Alive 2 years	0
63 F	Chromophobe Adenoma	Cobalt	Headache	+	+	Alive 2 years	CSF rhinorrhea, transient
35 F	Carcinoma breast with metastasis	Oophorectomy; chemotherapy; cobalt.	Back and chest pain; multiple bone metastasis	+	-	Died 3 months post-op	Biopsy showed adenocarcinoma of pituitary
51 F	Carcinoma breast with metastasis	Oophorectomy; cobalt.	Knee and spine pain; spinal metastasis	+	-	Alive 1 year	Transient diabetes insipidus, recurrence chest lesions
55 F	Carcinoma breast with metastasis.	Oophorectomy; cobalt.	Chest pain; dyspnea	+	-	Alive 1 year	Transient diabetes insipidus, recurrence chest lesions
33 F	Carcinoma breast with metastasis	Oophorectomy; cobalt	Pain left hip; chest metastasis	+	-	Alive 1 year	Recurrence chest lesions
49 F	Carcinoma breast with metastasis	Oophorectomy; cobalt	Pain back; lung and bone metastasis	+	+	Alive 7 months	Diabetes insipidus, transient
55 M	Carcinoma prostate with metastasis	Orchidectomy; estrogen, cobalt	Pain; boney metastasis	+	+	Alive	0
69 M	Carcinoma prostate with metastasis	Orchidectomy; estrogen; chemotherapy.	Severe pain, metastasis, congestive cardiac failure and peritoneal and pleural effusion.	-	-	Died 7 days	Cardiac failure
39 M	Diabetic retinopathy	Laser photo-coagulation of retina	Vision poor, OD; blood vitreous	+	+	Alive 1 year	Reduced insulin need
48 M	Diabetic retinopathy	Laser photo-coagulation of retina.	Vision hand movement OS; blood vitreous	+	-	Alive 1 year 6 months	0

hormone elevation and bone and joint pains are important measures. Following cryohypophysectomy, acromegalic patients showed subjective and objective improvement, as defined above, and growth hormone returned to normal level in three of the four cases. In the fourth case, it was lower than the pre-operative level but was still higher than normal. The remaining two cases of chromophobe adenoma have also shown improvement. Headache in both cases was almost completely relieved.

The five cases of breast carcinoma with metastasis who had previously had oophorectomy and radiotherapy showed initial improvement, followed by progression of metastasis. All complained of bone pains, which were relieved in each case although mild analgesics were required occasionally. There was objective and subjective improvement in one patient and subjective improvement in four cases. All patients were feeling much better, but pulmonary and skeletal metastasis progressed after temporary cessation of growth. One of these patients had a positive biopsy (adenocarcinoma in the pituitary gland) and died three months after surgery. She was the only one who had persistent diabetes insipidus, but she was controlled by Diapid® nasal spray.

The two patients with prostatic carcinoma showed relief of pain following cryohypophysectomy. They had previously been treated with cobalt therapy, estrogen and orchiectomy with limited success. One is alive and has subjective and objective improvement, while the other died seven days post-operatively due to respiratory and cardiac failure. He had pleural and peritoneal effusions and severe dyspnea before surgery. The two patients with diabetic retinopathy tolerated the procedure well. One has shown objective and subjective improvement, with improved visual acuity. The other had slight visual improvement, but again regressed after three months.

Complications

Cerebrospinal fluid rhinorrhea was present in one patient for a short time, but stopped spontaneously. Four patients had diabetes insipidus, one persistently and three transiently. Only two

of the 15 patients in this series died, one seven days and the other three months after surgery.

Comments

Stereotactic hypophysectomy was first done by Talairach and Tournoux of Paris⁹ using radioactive Yttrium⁹⁰ for the treatment of advanced metastatic breast carcinoma. This was soon accepted by other European surgeons and became an established technique. Rand *et al.*⁶ compared the results of 40 transnasal Yttrium⁹⁰ hypophysectomies with 17 transcranial operations and found the former especially valuable in that it was well-tolerated even by desperately sick patients. However, there were problems with interstitial irradiation and hence it has been abandoned by most. In 1961, Tytus and Ries¹⁰ conducted a series of experiments and were able to partially destroy the pituitary gland in dogs by cryosurgery. Cooper in 1963² attempted to destroy the pituitary by cryoprobe through the transfrontal route, but found it difficult due to immobility of the probe.

Since then, Rand,⁷ Wilson¹² and others¹¹ have utilized transnasal transphenoidal stereotactic cryohypophysectomy with success in metastatic mammary and prostatic carcinoma, progressive diabetic retinopathy, pituitary basophilism and acromegaly. There are many advantages of this procedure over the other methods of pituitary ablation: (1) The operation can be performed under local anesthesia, (2) Patients who are poor candidates for craniotomy tolerate the shorter and less stressful procedure very well, (3) The operative mortality is extremely low and, (4) Complete pituitary ablation can be achieved with accuracy, without damage to the adjacent vital structures.

There are, however, a few limitations. If the pituitary tumor extends 10mm beyond the diaphragm sella or if there is air seen in the anterior portion of the sella turcica on the pneumoencephalogram, an intracranial approach is probably better and safer. Otherwise, the transnasal operation is a safe procedure and can be repeated, if necessary with satisfactory results.

Rand *et al.* have reported excellent results in patients with acromegaly treated with stereotac-

tic cryohypophysectomy and in our cases of acromegaly, results have been similar. All have shown both subjective and objective improvement. The growth hormone levels returned to normal in all except one case.

In metastatic breast carcinoma, Rand reported a subjective-objective remission rate of 45 percent which is comparable to other techniques of hypophysectomy and adrenalectomy. Results were judged as subjective-objective similar to the criterion in this communication. Fracchia *et al.*³ compared the results of adrenalectomy and/or combined oophorectomy-adrenalectomy (500 cases) with transcranial or transsphenoidal hypophysectomy (203 cases) and found no statistical difference in the results. Adrenalectomy or hypophysectomy could be interchangeable. Adrenalectomy, however, does have more significant morbidity and mortality, (Fracchia)⁴ hence, transnasal hypophysectomy has an advantage over this method. The main reason for indifferent results in most cases is selection. Collins reported 394 cases of metastatic breast carcinoma who had hypophysectomy and a good response was obtained in 46.8 percent cases, 29 percent in unselected as opposed to 57 percent in cases selected with respect to hormone dependency. It is thus clear that if one can select those patients whose cancers are hormone dependent, cryohypophysectomy will become a more useful palliative operation. It is certainly more fruitful in relieving pain of osseous involvement. The procedure is also acceptable in selected men with metastatic carcinoma of the prostate in early and moderately advanced stages of bone metastasis.⁸

Pituitary ablation in the treatment of diabetic retinopathy was initially reported by Luft and associates.⁵ The observation by Paulsen of cessation of hemorrhagic retinopathy in a young diabetic woman following spontaneous postpartum pituitary infarction appears to have led to the rationale of this form of therapy. Rand⁶ operated on 32 cases; 24 have improved or remained stable and eight have shown progression. They suggest that advanced retinopathy should not be treated surgically as they do not seem to respond, presumably due to fixed and irreversible changes in the retina. Moderate and

progressive proliferative diabetic retinopathy seems to do well.

Mortality and morbidity of this procedure are low. Collins¹ reported 1 percent mortality in a series of 116 stereotactic cryohypophysectomies. Cerebrospinal fluid fistula was present in three cases requiring treatment, eight had diabetes insipidus and three had mild visual loss.

The number of patients having cryohypophysectomy for each disorder in this series is too small to draw any conclusion. However, it is clear from our experience and that of others that the procedure is safe and can be done in seriously ill patients with only slight risk as compared to other methods of hypophysectomy and adrenalectomy. When cerebrospinal fluid rhinorrhea develops, it nearly always stops on bed rest alone. If it persists it can be easily controlled by replugging the opening in the floor of the sella turcica using the stereotactic method. Meningeal infection has not been a problem in most series and we have had none in our cases.

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Old Short Hills Road, Livingston

Ophthalmology — Peter P. Walles, M.D.*

A twenty-four year old male is referred with a central scotoma of two-days duration in the right eye — past history negative, left eye normal. Visual acuity in the right eye is 20/40 with correction — pinhole no help. Pertinent physical findings are limited to the central macula with slight round retinal elevation with no signs of hemorrhage or scarring.

Differential Diagnosis?

1. Minute area of macular choroiditis
2. Macular edema of commotio retina
3. Thermal burn of the retina
4. Central serous choroidopathy (C.S.C.)
5. Macular pigment epithelial detachment
6. Posterior multifocal placoid pigment epithelialopathy (PMFPPE)

Additional Studies Performed

1. Visual fields — showed irregular sloping margined scotoma with positive photostress test
2. Fluorescein angiography — late leakage pinpoint in the retinal pigment epithelium with sub-retinal extravasation

Most Likely Diagnosis

Central serous choroidopathy

The other disease entities — minute area of macular choroiditis may resemble CSC in that the retinal edema can obscure the choroidal focus — usually can be differentiated with fluorescein angiography.

In macular edema of commotio retina one usually has history of trauma, i.e., contusion, and

so on, and often an associated choroidal rupture. Thermal burn of the retina history is often helpful, i.e., sun gazing, eclipse observing, and so on. Funduscopy in later stages usually shows a foveal or para-foveal hole. The visual field defect usually correlates with the central focus of the visible retinal lesion.

Macular pigment epithelial detachment usually can be differentiated from CSC in that the first condition commonly has early fluorescence and CSC usually is a pinpoint prolonged late-phase leakage. PMFPPE — clinically present more commonly bilaterally, usually with more than one focus. Fluorescein angiographic patterns differ in that PMFPPE lesions show an early blocked fluorescence and a staining in later phases.

Central serous choroidopathy is a disease entity that at times resolves spontaneously. Steroids and tranquilizers are of questionable value. Laser coagulation in certain cases can be used to seal the focal leak in long standing cases.

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*From "The Cooper Review" published by the Department of Medical Education, Cooper Medical Center, Camden, New Jersey, where Dr. Peter P. Walles, is Assistant Ophthalmologist

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Preliminary experience with a dynamic penile prosthesis in two cases of total organic erectile impotence demonstrates the difficulties and the advantages of this type of prosthesis compared with the static type. The results obtained suggest that the dynamic method warrants further investigation and use.

Treatment of Organic Erectile Impotence

Experience with the Scott Procedure

Robert B. Ambrose, M.D.*
Morristown

Two methods have been applied to the surgical treatment of erectile impotence: (1), introduction of a firm static prosthesis of inert material and, more recently,¹⁻⁵ (2), a dynamic prosthesis⁶ which permits erection or flaccidity upon desire.

Both methods have advantages and disadvantages. The static device does not result in actual change in the size of the penis; being semi-rigid it carries the common hazard of perforation of its soft tissue environment⁷ and, may not produce the desired degree of erection. The simplicity of design, however, makes for simple surgical implantation, reduced cost, and the threat of mechanical malfunctions less likely.

The dynamic prosthesis requires more time to implant (2 to 3 hours) and is much more complex and expensive. It has the distinct advantage of allowing a substantially rigid erection upon command for the duration, so to speak. The flexibility of the cylinders makes perforation extremely unlikely.

This paper presents preliminary experience with two cases.

Materials and Methods

The device consists of a reservoir in the suprapubic area, a pump in the scrotum and a pair of inflatable cylinders in the penis. Four one cm. long metal connectors join these components and link them into a fluid filled functional unit. The fluid is half water and half radio-opaque material. The implanted materials are made of silastic elastomer known to be well tolerated for chronic use. Suture material recommended is 0 and 000 prolene.

Operative Technique

The procedure can be accomplished through an incision extending from midway between the umbilicus and pubis to about one inch into the dorsum of the base of the penis.

(A) *The Cylinders:* (Figure 1) The inflatable cylinders are placed in the penis after making an incision in the tunica albuginea of each corpus cavernosum. These incisions are best made with a scalpel (bayonet type, Bard Parker #11) between two previously placed stay sutures of 0 prolene. Additional stay sutures in each incision satisfactorily elevate the albuginea, minimize blood loss (which is surprisingly minor), and facilitate the displacement downward of the erectile tissue from the undersurface of the tunica. This displacement is done easily by scissor dissection in one continuous passage from the base of the penis distally. The space created is fashioned into a tunnel by passing successively larger Hegar dilators to the distal termination of the corpus (immediately behind the coronal sulcus). In creating the proximal portion of the tunnel one must conform to the anatomic divergence of the corpora cavernosa at that area to avoid injury to the urethra.

Tunnel length can be ascertained by adding the depth to which the Hegar dilator is passed in both proximal and distal directions from the incision in the tunica. An appropriate pair of cylinders is thereby selected for insertion (range from 12 to 17 cm.). The act of insertion is difficult and is mastered only by patient trial and error; Scott finds a Cushing vascular forceps

*Dr. Ambrose is Director of Urology, Morristown Memorial Hospital, and Clinical Assistant Professor of Surgery, Rutgers Medical College, CMDNJ, Piscataway

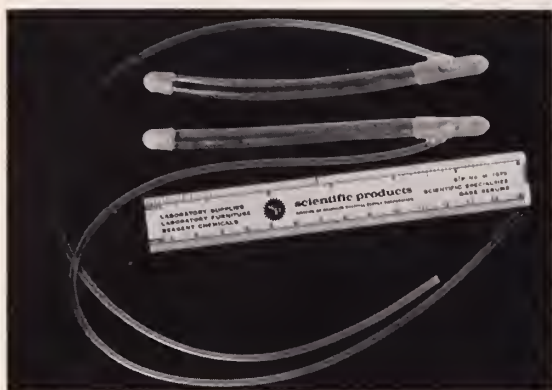


Figure 1 — Paired inflatable cylinders reinforced at each end.

most useful whereas the author prefers a uterine dressing forceps. In closing the albuginea incisions one must avoid puncturing the cylinders.

The right and left cylinder tubing connections are made to a Y-tube (Figure 2) placed in the prevesical space. Connections are made just outside the external inguinal rings so that they are readily accessible for repair should leakage occur at the connector sites. Sterile "knitting needle" tube passers make it simple to maneuver the tubing ends to proper location.

(B) *Reservoir and Pump:* (Figures 3 and 4) The other two major components (reservoir and pump) are positioned behind the rectus muscle and in the scrotal compartment respectively by blunt dissection. It is important to position the pump in as low a scrotal site as possible. This permits the patient to activate it with ease and without discomfort.

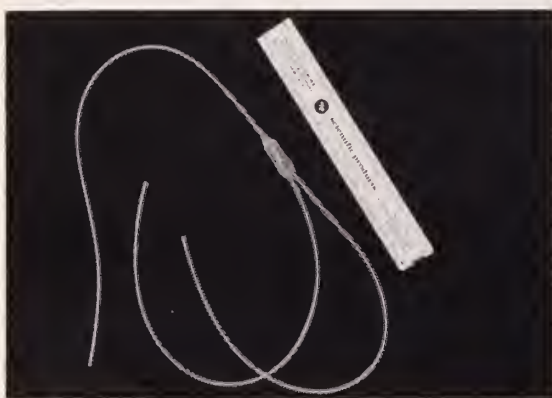


Figure 2 — Y-tube joining the scrotal pump to the cylinders.



Figure 3 — Silastic reservoir, capacity 60 cc., with dacron tab at top for suturing to under surface of rectus muscle.

Thorough and repeated irrigations of the operative field with antibiotic solution (we used Neobacin®) reduces the possibility of infection which could conceivably require removal of the prosthesis for control. No drains are required.

Post-operatively the penis was kept in a semi-erect state for 48-72 hours which effectively achieved hemostasis. In neither of the two cases reported herein nor in Scott's experience⁸ has bleeding or penile pain been a problem. Both patients, however, minded manual manipulation of the pump, presumably secondary to moderate scrotal ecchymosis and edema. Catheter drainage was maintained for 24 hours.

No compression dressing was used and penile edema was not a problem. In each case daily activation (i.e., pumping up to capacity followed by deflation) was carried out initially by the physician and thereafter by the patient, under supervision.

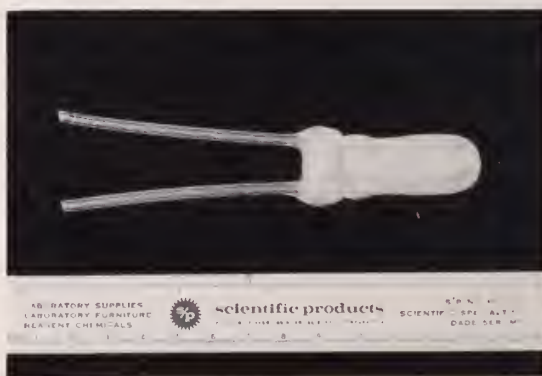


Figure 4 — Double-limb pump connects reservoir to Y-tube. Release valve is located at upper end.

Case Reports

Case #1 — (Figures 5A and 5B) A 61-year-old male underwent radical retropubic prostatectomy five years prior to penile implant. Although rendered impotent by this surgery the patient retained normal libido and admitted to sexual activity with his wife which resulted in a quasi-orgasm without ejaculation.

Operative implant of a pair of 15 cm. cylinders with a 55 cc reservoir was performed uneventfully. It was noted at completion of surgery that at full erection there was a 15° tilt to



Figure 5A — Flaccid penis, case #1.



Figure 5B — Erect penis, case #1.

the left. The reason for this was shown subsequently by x-ray to be secondary to unequal inflation of the cylinders. Scott⁸ has seen similar problems in his patients and finds this acceptable if intromission can be accomplished despite the deviation.

This patient was discharged on the 5th postoperative day. He complained only of scrotal discomfort which gradually subsided over a period of 2 to 3 weeks. No penile pain was experienced until he returned from a four-day vacation during which time he did not activate the device at all; he did this intentionally because he feared inability to deflate the erect penis. Upon return to my office he experienced intense pain

on inflation and only with great reluctance did he gradually regain the ability and confidence necessary to activate the prosthesis on a daily basis.

Approximately three months after surgery a leak in the reservoir was demonstrable by fluoroscopy. The reservoir was replaced and the prosthesis once again became fully operative.

Case #2 — A 59-year-old diabetic had noticed decreasing ability to achieve and maintain penile erection over a 4-year period. Penile implant using 13 cm. cylinders and 50 cc in the reservoir was performed. He experienced an uneventful recovery, with the exception of scrotal pain similar to the first patient. He resumed sexual relations within six weeks to his and his partner's complete satisfaction.

Discussion

The Scott prosthesis represents a landmark in genito-urinary surgery because of the dynamic principles involved. A related prosthesis for treatment of urinary incontinence in both sexes has already proved worthwhile.⁹

Patient selection requires thorough preoperative consultation and evaluation by the physician. Detailed explanation is mandatory so that a patient and his wife are familiar with the operative procedure and the mechanics involved along with the possible mechanical failures, their means of detection and alternatives for correction, should they occur. Early results with the Scott prosthesis are encouraging.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacities. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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RAST (Radioallergosorbent test) as a means of specific allergic diagnosis is commercially available. However, in general it has not proved to be cheaper nor more accurate than history taking, along with well-done skin testing. It is, however, useful in patients with dermographia, eczema, or non-reactive skin.

RAST: A New Method for the Diagnosis of Allergy

Michael S. Mattikow, M.D./Wayne*

Ever since the Ishizakas showed that the antibody causing allergic reactions belongs to a distinct class of antibody, designated as IgE (reagin), attempts have been made to use this knowledge to develop an *in-vitro* test for specific allergic diagnosis.¹

IgE appears in the serum in nanogram (ng) amounts which are too small to be measured by the usual tests for antibodies of the IgG, IgA, IgM classes. Wide, Bennick, and Johansson developed a more sensitive test called RAST (Radioallergosorbent test).²

Recently, three commercial firms† in and near New Jersey began to offer the RAST as a diagnostic tool for the clinician. This paper is an explanation of the method, reliability, uses and limitations of this test.

The theory of this test is quite simple. (Figure) A specific allergen (such as ragweed) is coupled to cellulose particles which results in an insoluble complex (step #1). Next, the serum to be tested is added to the cellulose-allergen complex. If antibody specific for that allergen (ragweed) is present in the serum, it attaches to the allergen forming a cellulose-allergen-antibody complex (step #2). This is washed to remove excess serum. Next, antibody produced in animals against human IgE and made radio-active with I¹²⁵ or I¹³¹ is added to the complex (step #3). The IgE (anti ragweed) already in the complex acts as an antigen and the radioactive anti-human IgE antibody couples to it in amounts corresponding to the amount of specific IgE antibody that was in the original test serum. This is washed again to remove excess antibody. By

measuring the amount of radioactivity present and comparing it to a control, results ranging from 0 (no antibody) to + 4 (strongly positive) are obtained. The commercial laboratories use modified versions of this test applying competitive protein binding.

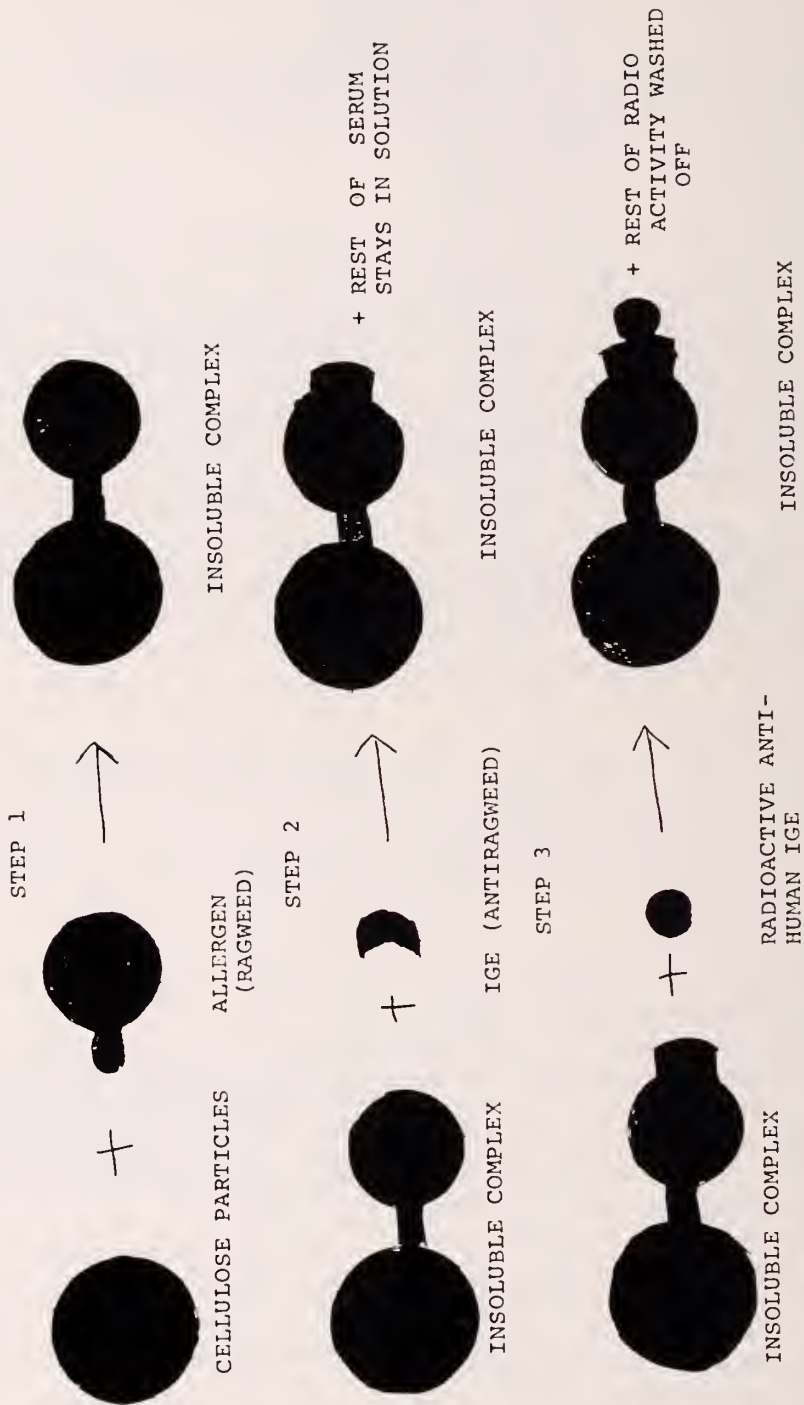
Clinical Studies of RAST

The most accurate means of making allergic diagnosis is by provoking the patient with the allergen suspected from a carefully taken history. If symptoms appear by introducing an allergen, it is unquestionable proof of its guilt especially if compared to a blind placebo. On the other hand, if no symptoms occur the allergen is innocent. To evaluate different means of allergy diagnosis whether they be history, skin tests or *in-vitro* tests such as RAST, results must be compared to provocation. This has been done in various studies of the RAST.

In 1971, Aas and Johansson published the results of testing five allergens on 29 patients.³ They found an overall reliability using the RAST of 73 percent. When using skin tests and history, an accuracy of 82 percent was obtained. They noted a greater accuracy in the more sensitive patients and in the completely non-atopic patient. They also noted the antigen used very much affected the accuracy of RAST. This ranged from a 93 percent reliability with cod fish (100 percent with history and skin tests) down to a 59 percent accuracy with house dust. Interestingly, house dust was the only allergen

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†Genatom-East Orange, Pharmacia-Piscataway, Hollister Stier-Yeadon, Pa.



where RAST (59 percent) was more accurate than history and skin tests (34 percent).

Lichtenstein and Ishizakas, using patients sensitive to grass or ragweed, showed in the slightly sensitive patient a negative RAST might be found with positive skin tests.⁴ They also found two false positive RASTs. They felt the only advantage to the RAST was convenience to the patient but that skin testing, with grass or ragweed at least, was more sensitive.

Hoffman and Haddad, in 1974, published the results of 302 patients tested against 13 different inhalant allergens.⁵ Their results indicate an overall accuracy of 82 percent with RAST. As in other studies, they found the accuracy depended on the antigen with a 93 percent accuracy obtained with grasses and only 58 percent with dust.

They found two types of patients with negative skin tests and positive RAST. These were patients with severe atopic dermatitis or those with suppressed skin reactions due to drugs such as antihistamines. They felt that scratch testing was a reliable method for making allergic diagnosis and that RAST was rarely necessary. They concluded . . .

"The cases in which the RAST add substantial information includes children with severe atopic dermatitis, suppressed skin reactivity and dermographia."

Discussion

Ever since skin testing was introduced to help diagnose allergic problems, disenchantment with its accuracy and the need for scratching, pricking or needling the patient's skin has caused researchers and clinicians to look for other methods. Certainly, false positives are common with skin testing, however, quantitative skin tests have shown the test to be reproducible and, if used along with history, an accurate means of diagnosis. Provocative testing is certainly the most accurate method but the time involved, the equipment needed, the danger to the patient, and the limitation in the number of tests that can be done has precluded its general use in clinical practice.

In evaluating RAST, let's consider Johansson's criteria for replacing skin tests with RAST.⁶

1. Accuracy and reliability (will it do away with false negatives and positives?)
2. Convenience for patient and doctor.
3. Capacity with respect to time needed for each patient.
4. Total cost

From the studies mentioned before, it becomes obvious that overall the RAST is no more accurate than skin testing. False negatives were present with RAST in patients where skin testing was positive. It appears that skin tests are more reliable in the only slightly sensitive patient. False positives, however, seem less prevalent with RAST. Also RAST has proved more accurate in patients with eczema, dermographia, or those on skin-suppressive drugs such as antihistamines.

The nature of the antigen in both skin testing and RAST seems to affect accuracy. Baer pointed out that excellent results were obtained with highly purified allergens while with less pure antigen results were not as accurate. More false positive tests were noted with RAST. However, with less pure antigens, such as dust, both tests fall short and other methods of diagnosis must be discovered.

This problem also occurs with reactions to foods or drugs. Here again difficulty in purifying the antigen makes RAST interpretation difficult. Of 299 individual food intolerances in 127 patients tested by Hoffman and Haddad, 50 percent had positive RAST.⁵ Like food skin testing, correlation was best with anaphylactoid symptoms and less accurate with gastrointestinal symptoms. With drugs penicillin and insulin are probably the only antigens well defined enough for RAST.

Baer, who is Director, Division of Bacterial Products, Bureau of Biologics, Food and Drug Administration, summed up his feelings about RAST.⁷

"... Furthermore, most of the data have been accumulated with only a few allergens. Much more data with many allergens are needed before the test can be taken from the research laboratory and used as a general diagnostic tool."

Interestingly, in our experience the rare patient who is skin test negative, in spite of a history suggestive of a specific allergen, has proved also to be negative to RAST. This may indicate classes of antibodies other than IgE are involved in such cases.

Criteria 2 and 3 favor RAST, since the removal of blood with one venous puncture is certainly more convenient and less time consuming to both patient and doctor than skin testing. However, commercial RAST is very limited in the number of allergens available at present. The commercial labs offer tests for approximately 50 inhalant allergens, many of which cross-react and others which are not clinically significant in this part of the country.

Criteria 4 overwhelmingly favors skin testing. RAST costs \$50 for 10 tests while skin testing in the doctor's office costs approximately \$20 to \$25 per visit with of 10 to 14 skin tests being performed.

In summary, RAST in clinical practice has not proved to be more accurate or cheaper than skin testing and history in the average patient. It has, however, the advantage of convenience.

Presently, RAST tests are suggested for patients with atopic dermatitis, dermographia or non-reactive skin. It has also proved useful in the patient who is convinced he is allergic but by history and skin tests appears not to be.

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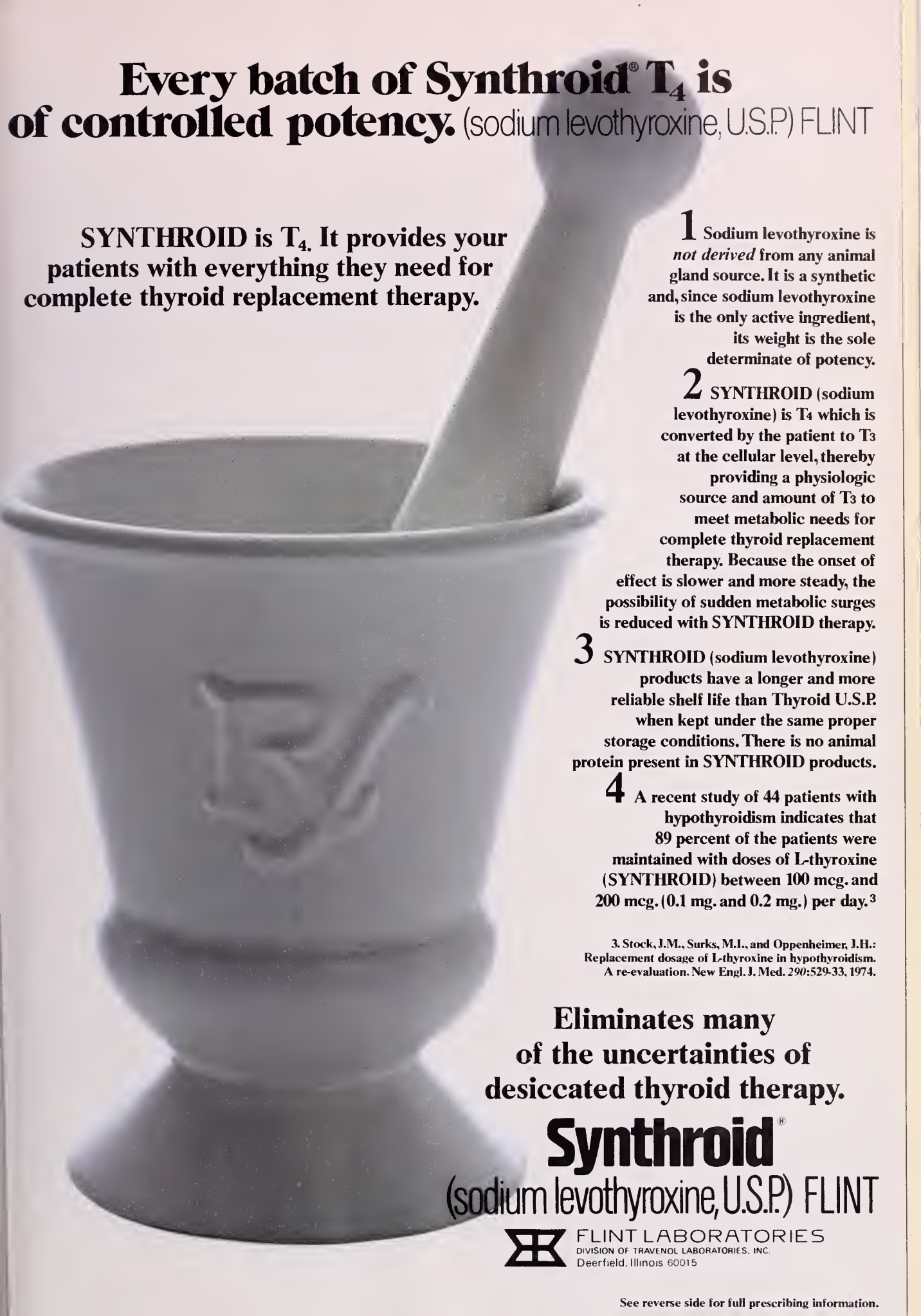


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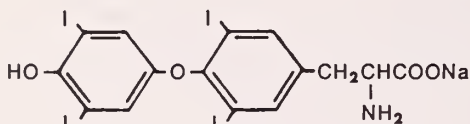
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Sodium Levothyroxine

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Contraindications

SYNTHROID (sodium levothyroxine) products serve as specific replacement therapy for reduced or absent thyroid function of any etiology. SYNTHROID Injection can be used intravenously whenever a rapid onset of effect is critical, and either intravenously or intramuscularly in hypothyroid patients whenever the oral route is precluded for long periods of time.

Contraindications

There are no absolute contraindications to SYNTHROID (sodium levothyroxine) therapy. Relative contraindications include acute myocardial infarction, uncorrected adrenal insufficiency and thyrotoxicosis. (See WARNINGS)

Warnings

Patients with cardiovascular diseases warrant particularly close attention during the restoration of normal thyroid function by any thyroid drug. In such cases, low initial dosage increased slowly by small increments is indicated. Occasionally, the cardiovascular capacity of the patient is so compromised that the metabolic demands of the normal thyroid state cannot be met. Clinical judgment will then dictate either a less-than-complete restoration of thyroid status or reduction in thyroid dosage.

Endocrine disorders such as diabetes mellitus, adrenal insufficiency (Addison's disease), hypopituitarism and diabetes insipidus are characterized by signs and symptoms which may be diminished in severity or obscured by hypothyroidism. SYNTHROID (sodium levothyroxine) therapy for such patients may aggravate the intensity of previously obscured symptoms and require appropriate adjustment of therapeutic measures directed at these concomitant disorders.

Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdose with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) Tablets, the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) Tablets daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdose per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID Injection may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsiveness within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID Injection produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID Injection by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID Tablets is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) Tablets are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for Injection is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. Use immediately after reconstitution. Discard any unused portion.



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Early shunt thrombosis is a significant problem affecting the longevity of the Quinton-Scribner dialysis shunt. Seven cases of early shunt thrombosis, together with the results of Fogarty catheter embolectomy following the withdrawal of the silastic loop from its subcutaneous pocket, are presented. Prophylactic antibiotics were used and no case of infection or immediate re-thrombosis was encountered in this series. The method appears to have increased the survival of shunts which would ordinarily have to be revised.

Fogarty Catheter Embolectomy in Early Thrombosis of the Quinton-Scribner Dialysis Shunt*

**H. Stephen Fletcher, M.D. and
John Ambrose, M.D./Livingston**

Improvement in materials and surgical technique have extended the life of the Quinton-Scribner shunt to the point where it is now not unusual to have a single shunt last up to 24 months and beyond. A limiting factor in shunt survival is early thrombosis. Excluding technical error in the placement of the teflon vessel tip, this may be due to prolonged flexion of the shunted forearm, episodes of hypotension or iatrogenic infusion of hypertonic solutions through the shunt. The configuration of the arterial and venous limbs of the shunt now in use do not easily lend themselves to declotting with an embolectomy catheter necessitating revision of the shunt in many instances. By a simple maneuver we were able to thread a Fogarty embolectomy catheter through the shunt and thereby accomplish declotting. Seven cases in which this technique was used are the subject of this report.

Technique

The shunts used at Saint Barnabas Medical Center are the standard Quinton-Scribner teflon-silastic shunt manufactured by Extracorporeal Medical Specialties, Inc. The #413 teflon vessel tip is the standard cannula used. The inner diameter of this tip is 2.5 mm. and will admit a #4 Fogarty embolectomy catheter.** At the bedside the skin is first prepped with a povidone-iodine solution (Betadine®)† and then the shunt area is sterilely draped. The shunt is disconnected and the curved portion of the shunt limb to be declotted is withdrawn with gentle

traction from its subcutaneous pocket (figure 1). Care is taken to minimize the manipulation of the vessel tip by partially immobilizing it with slight digital pressure over the cannula site.

Once out of its tunnel, the flexible tubing is straightened and a #4 Fogarty embolectomy catheter is inserted (figure 2). It is then possible, with minimal difficulty, to pass the catheter through the shunt into the thrombosed vessel. Embolectomy is then performed in the usual manner. While it is frequently possible to pass the catheter into the axillary and subclavian veins from the venous limb, a short distance beyond the vessel tip is usually all that is needed to open the arterial limb and, in fact, further insertion could force thrombus to embolize down the ulnar artery and result in digital loss or ischemia.

Following successful declotting, both limbs of the shunt are irrigated with a solution containing 2500 units of sodium heparin in 250 cc. of saline. The silastic loop is then carefully returned to its pocket and the shunt reconnected. All patients were dialyzed immediately upon completion of the declotting procedure.

Case Material and Results

The data from seven cases in which this method was used is summarized in Table 1. All patients

*From the Department of Surgery, Saint Barnabas Medical Center, Livingston, New Jersey 07039. Reprint requests to: H. Stephen Fletcher, M.D. 201 S. Livingston Avenue, Livingston, New Jersey 07039

**Fogarty Embolectomy Catheter, Edwards Laboratories
†Betadine, The Perdue Frederick Company



Figure 1 — The removal of the silastic shunt limb from its subcutaneous pocket using digital pressure over the cannula site.



Figure 2 — Insertion of the Fogarty Catheter into silastic shunt limb.

were being treated by acute or chronic hemodialysis at Saint Barnabas Medical Center. There were five females and two males; the age range was 34 to 70. Four patients had chronic renal disease while three had acute tubular necrosis. The average age of the shunts at the time of thrombosis was 31 days with a range of two to 60 days. In five cases (1, 3, 5, 6 and 7), this was their first Quinton-Scribner shunt. All shunts were placed in the forearm^{1, 2, 3} except for one which was placed in the profunda brachial artery and cephalic vein. Attempts at declotting by standard method using the Cobe declotting tray^{††} had previously failed, in one or both limbs of the shunt, in all cases.

In four patients, thrombosis was noted after hypotensive episodes. Two patients developed thrombosis after sleeping with the shunt-containing arm flexed; coil rupture was responsible in case 7. Following the procedure, the shunts remained patent in two patients for greater than 90 days. One shunt (case 4) thrombosed again after the patient slept with the arm flexed; revision was performed at another hospital. The shunt remained patent in patients 3 and 6 until it was no longer needed and in patient

††Cobe Declotting Tray, Cobe Laboratories

Table I

Summary of cases with thrombosed Quinton-Scribner shunts declotted by the Fogarty embolectomy catheter

Case	Age	Sex	Diagnosis	Age of shunt thrombosis	Cause of thrombosis	Vessels declotted	Patency post-embolectomy
1.	58	F	Diabetes Arteriolar nephrosclerosis	60 days	patient slept with forearm flexed	artery, vein	140 days
2.	56	F	Arteriolar nephrosclerosis	1 day	hypotensive episode	vein	21 days
3.	34	M	Hypertension Acute tubular necrosis	2 days	hypotensive episode	artery, vein	10 days
4.	56	F	Diabetes Arteriolar nephrosclerosis	14 days	patient slept with forearm flexed	artery, vein	70 days
5.	72	M	Acute tubular necrosis	13 days	clotted on dialysis following coil rupture	artery, vein	failure (artery)
6.	61	F	Diabetic glomerulonephropathy	42 days	patient slept with forearm flexed	artery, vein	147 days
7.	56	F	Leukemia Acute tubular necrosis	15 days	hypotensive episode	vein	14 days

2 until this patient's death. In case 5, the venous limb was successfully declotted but a good flow could not be established despite the fact that we were able to pass the catheter into the arterial limb. This necessitated revision of the arterial end of the shunt and was considered a failure of the technique.

Discussion

Although the arteriovenous fistula is becoming the preferred procedure for maintenance on hemodialysis in many centers, the teflon-silastic arteriovenous shunt remains of considerable value for short term dialysis and for chronic maintenance while a surgically created fistula matures. With improvement in technique and management, the average life of the Quinton-Scribner shunt has increased.

Thrombosis, which is a major cause of shunt failure, can be subdivided into immediate, early, and late thrombosis. Immediate failure occurs during the first twenty-four hours; it is often due to a technical error in the placement of the cannula and almost always requires revision of the shunt. Late thrombosis, on the other hand, is most often due to vascular changes in the cannulated vessels and also necessitates revision.^{4, 5}

Conversely, early failure is very frequently a result of either an episode of hypotension, mechanical obstruction of the venous runoff (by prolonged flexion of the forearm) or infusion of a hypertonic solution through the shunt. In this instance, the shunt can be successfully treated with a reasonable hope of long term survival of the shunt. The standard declotting procedure, which involves the use of a soft polyethylene tubing with a syringe for suction, is frequently unsuccessful. In these cases, the Fogarty catheter method described has been of value in our hands.

Removal of the silastic cannula from its subcutaneous pocket has not proved to be difficult

even with shunts which have been in place for 60 days. Beyond this time, the shunt limb tends to become fixed in its pocket by fibrosis and removal is difficult. Although it is a potential problem, we have not noted disruption of the vascular connection during the procedure. Considering that these shunts normally have to be revised, the risk appears justifiable. Advancement of the Fogarty catheter through the tip of the cannula is not difficult with gentle pressure. Infections have not been seen since antibiotics are used prophylactically. Anticoagulants were used in only two cases following the procedure; none of the shunts re-thrombosed in the immediate post-declotting period, so we do not feel routine anticoagulation is needed.

One goal in long term hemodialysis is the preservation of a particular shunt for as long as possible in order to preserve other cannulation sites. In patients with acute tubular necrosis, where recovery is predicted, morbidity is reduced if only one shunt need be placed. We feel that the technique described has significant value in extending the life of the teflon silastic shunt by eliminating early thrombosis as a cause of shunt failure.

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A specially designed flotation unit has been in use at the Jersey City Medical Center since September 1973 to aid in the prevention of decubitus ulcers. This unit has proved to be a practical, unique, and eminently successful method in preventing the result of unavoidable immobility. A study involving thirty patients, representing 1,275 patient days on total flotation therapy has shown this new modality to be a completely safe and effective treatment in the prevention of decubitus ulcers.

Experience with a Flotation Unit for Prevention of Decubitus Ulcers.*

**Paul J. Harper, M.D.,
Joyce M. Rocko, M.D., and
Joseph J. Timmes, M.D./Jersey City**

Decubitus ulcers are areas of ischemic necrosis caused by constant pressure. The most important factor appears to be pressure leading to tissue ischemia and eventual necrosis, but additional etiologic factors include nutritional status, heat, moisture, shearing force, hygiene and friction.¹

Seigel and his group² demonstrated that the pressure to close capillaries and cause tissue necrosis is about 20 millimeters of Mercury. They further demonstrated that a patient on a water bed would not exceed this pressure, so could remain indefinitely on the water bed and never develop a decubitus ulcer.

Water beds inherently have difficulties associated with their use which render them unattractive for general use in a large community hospital (see table I). To obviate these problems, we designed a flotation unit which consists of a multicompartmentalized water mattress. It fits on a standard hospital bed, is easily transported and weighs less than 150 lbs when filled with water. The design of this unit permits the patient to be placed in any position required for treatment and for the prevention of pulmonary complications without losing the therapeutic benefits of flotation therapy (see figure 1).

Materials and Methods

The flotation unit is composed of five sections made almost entirely of polyvinyl chloride. The

first section is an inflatable air frame, three inches in height, whose width and height correspond to those of a standard hospital mattress. The second section, a one-inch thick polyfoam pad sealed in vinyl, rests within the space formed by the walls of the air frame. The final three sections consist of equally-sized water bladders designed with a number of longitudinal baffles to prevent excess water motion and to allow the flotation unit to be placed in any position without the water pooling at the bottom of the bladder. Thus, flotation of the patient is maintained at all times.

Table I

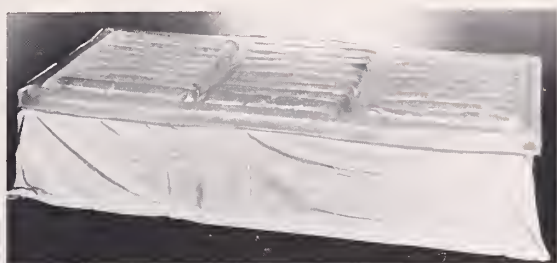
Comparison of Features of Water Beds

	Conventional Thermo-Cryonic	
Transportation of bed	Difficult	Easy
Weight	500 lbs.	150 lbs.
Positioning of patient	Flat	As desired
Section removal*	Impossible	Easy
Amount of H ₂ O lost with leaks	all	8 gal.
Cost	\$500	Appr. \$150

*for use in wheelchair, lounge chair, etc.

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*This work is from the Jersey City Medical Center where Dr. Harper and Dr. Rocko are senior residents in surgery. Dr. Timmes is director of Surgery.



Bard Flotation System used in the study

An additional benefit is that a section of the unit may be removed and placed on a chair so a patient maintains flotation during transportation or in time spent out of bed before ambulation is possible.

Clinical Study

A group of 30 patients from the surgical department of the Jersey City Medical Center were

selected for placement on the flotation units. These patients had no evidence of decubitus ulcers prior to being placed on the units but were considered to be bed-sore prone. They were victims of multiple trauma, or patients who were comatose or immobilized due to neurosurgical or orthopedic disorders.

Instructions were given to the nurses not to turn or reposition the patients except for the administration of general nursing duties. No pads, pillows, draw sheets or impermeable materials were placed between the patients and the flotation unit except one sheet. The head of the bed was to be elevated every two hours, or as needed, to prevent pulmonary complications.

When the patients were to be transported to another area of the hospital for any extended periods of time (e.g. to x-ray or physiotherapy

Table II

Patients on Study for Prevention of Beds Sores

<i>Skin Condition</i>			<i>Days</i>		<i>Days</i>	<i>Skin Condition</i>
<i>Patient</i>	<i>Age</i>	<i>Diagnosis</i>			<i>on Unit</i>	<i>at the end of study</i>
1	72	Subdural hygroma, coma			10	intact
2	65	Myocardial infarction			26	intact
3	42	Multiple fractures			42	intact
4	63	Malnutrition, incontinence, senility			16	hyperemic
5	65	Fractured hip, myocardial infarction, in traction			38	intact
6	80	Multiple contusions, cerebrovascular accident, diabetes mellitus			22	intact
7	63	Fractured hip in traction, diabetes mellitus			20	intact
8	75	Fractured hip in traction			19	intact
9	69	Peripheral vascular disease, diabetes mellitus, B K amputation (bilateral)			57	intact
10	74	Cerebrovascular accident			47	intact
11	57	Contractures both lower extremities, fractured hip, in traction			50	intact
12	80	Coma — unknown etiology			30	intact
13	84	Fractured hip			25	intact
14	69	Diabetes mellitus, peripheral vascular disease, gangrene			30	intact
15	58	Fractured hip in traction			36	intact
16	31	Spina bifida, paraplegia, post-operative skin graft of buttock			20	intact
17	75	Fractured hip in traction, malnutrition			15	intact
18	83	Fractured hip in traction			66	intact
19	82	Fractured hip in traction			28	intact
20	80	Fractured hip in traction			26	intact
21	79	Intestinal obstruction (post-operative), senility			15	intact
22	80	Gangrene right leg			46	intact
23	61	Perforated duodenal ulcer, renal failure			8	intact
24	42	Multiple fractures, malnutrition, in traction			27	intact
25	21	Multiple trauma, multiple fractures, multiple operative procedures			59	intact
26	32	Quadriplegic			200	intact
27	30	Paraplegic			185	intact
28	75	Fractured hip in traction			30	intact
29	60	Fractured hip, multiple trauma			45	intact
30	67	Multiple trauma, senility			37	intact

departments) they were sent on the water mattress. If they were conveyed in a wheelchair, a section of the flotation unit was removed from the bed and the patient was transferred on it. In this way, the patients were maintained on constant flotation until they were in a clinical condition to have no further need of flotation. The only exception to this rule was for time spent in the operating room.

A patient was considered not to need flotation therapy if he was ambulatory. When a patient reached this stage in his recovery, he was removed from the study. Patients were also removed from the study if they were transferred out of our hospital to an extended care facility unless the flotation unit accompanied him (Patient #26 — in this case, close followups were accomplished by the author to insure adherence to the study criteria).

Results

Table II outlines our experience with 30 patients ranging in age from 21 to 84 years (average 63.8) who represented 1275 patient days on total flotation therapy. This represents an average stay of 42.5 days on the flotation unit, with a range of 8 to 200 days. The table clearly indicates that all 30 patients terminated their time on the flotation unit with intact skin. There was no evidence of skin breakdown in any patient, although patient #4 did have a hyperemic area on her buttocks.

Two patients underwent skin grafting while on flotation therapy (#16 and #25). Both of these patients were placed on the flotation units immediately post-operatively, lying directly on the grafts. In each case, there was an excellent take of the grafts. Daily clinical evaluations and weekly blood gas studies and chest x-rays failed to reveal evidence of pulmonary insufficiency.

Conclusions

Total flotation therapy has been shown to be a completely effective modality in the prevention of decubitus ulcer formation. Patients may be easily repositioned by raising or lowering the head of the bed in the conventional manner, thereby eliminating pulmonary insufficiency. The comfort of the patients is significantly improved while on the flotation units since painful repositioning is no longer needed. These flotation units offer an inexpensive and practical method of preventing a severe complication of prolonged enforced bed rest.

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- (d) Immediate protected weight-bearing.

Answer: (c) Early knee motion has been clinically well demonstrated to aid in early joint

rehabilitation.^{1, 2} Generally motion is begun two weeks post-injury or surgery. Quadriceps rehabilitation is another important factor.

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*From "The Cooper Review" published by Cooper Medical Center, Camden, where Dr. Cooper is orthopedic resident.

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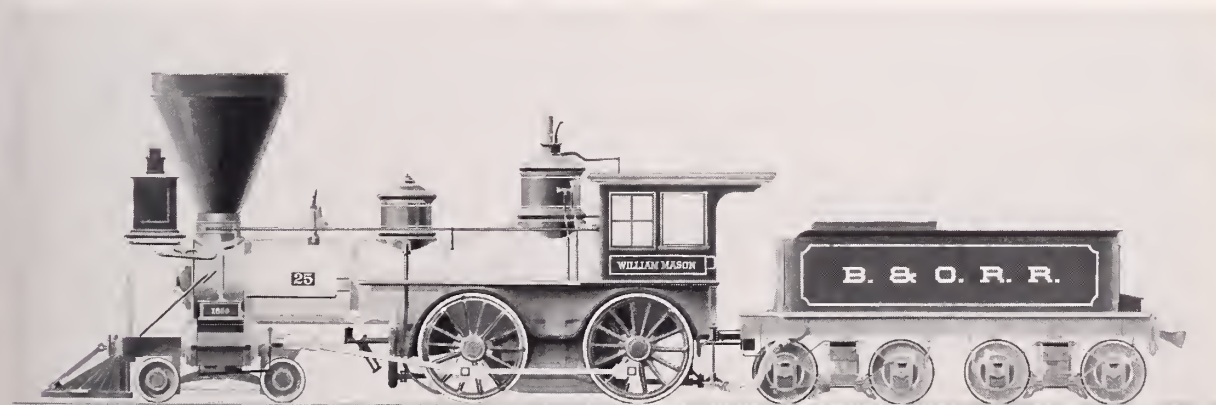
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The William Mason (1856)

CASE REPORTS

A 28-year-old man with cirrhosis of the liver developed massive intraperitoneal hemorrhage following rupture of an intraperitoneal varix. Although a 50 percent reduction of portal pressure was obtained following portocaval shunt, gastrointestinal hemorrhage recurred. A large arteriovenous fistula between the hepatic artery and hepatic vein was demonstrated during the workup for recurrent upper gastrointestinal hemorrhage.

Massive Intraperitoneal Hemorrhage and Intrahepatic Arteriovenous Fistula in Hepatic Cirrhosis*

**N. M. Doromal, M.D., Ridgewood,
Philip Middleton, M.D., and
J. N. Keshishian, M.D.,
Washington, D.C.**

Massive hemorrhage from vascular abnormalities associated with cirrhosis of the liver and portal hypertension can be catastrophic. A frequent source of the hemorrhage is from ruptured esophageal varices. Other less-often reported life threatening sites are from ruptured intraluminal intestinal varices,^{1, 5, 9} mesenteric varices¹⁵ and vaginal varices.⁸

Arteriovenous fistula of the hepatoportal system is most commonly due to trauma.^{3, 4, 11, 14, 16} Congenital arteriovenous fistulae have also been reported.^{7, 10}

This case report deals with a cirrhotic patient who had a massive intraperitoneal hemorrhage and a large intrahepatic arteriovenous fistula — two uncommon occurrences.

Case Report

A 28-year-old man was admitted to the Washington Hospital Center with acute generalized abdominal pain associated with vomiting of "coffee-ground" material. There was no history of trauma. Past history revealed heavy alcoholic consumption for several years. One year prior to this admission he was admitted to another hospital because of gastrointestinal hemorrhage probably secondary to cirrhosis of the liver and esophageal varices. Three years ago the patient sustained a superficial stab wound on his flank.

Physical examination revealed a well developed, poorly nourished man in shock. The blood pressure was 80/60 and

the pulse rate was 140 per minute. His abdomen was distended and tense, there was generalized rebound tenderness. Bowel sounds were hypoactive. The gastric aspirate was positive for blood and the stool was negative for blood. Abdominal paracentesis yielded dark non-clotting blood.

Laboratory data showed a hematocrit of 24.6 percent, hemoglobin of 7.8 grams, white blood cell count 18,200/cu. mm., platelet count 38,000, prothrombin time — control 14 seconds, patient 23 seconds, partial thromboplastin time — control 38 seconds, patient 69 seconds, blood urea nitrogen 9 mg/100 ml, sodium 141 mEq/liter, chloride 109 mEq/liter, potassium 4.7 mEq/liter, serum amylase 107 units. Analysis of the peritoneal fluid revealed amylase of 370 units and ammonia of 14.4 mg/100 ml.

Immediate exploratory laparotomy revealed three liters of dark blood in the abdominal cavity. The spleen was intact and the liver showed changes consistent with cirrhosis. There were numerous varices scattered throughout the abdominal cavity. The single source of bleeding was from a ruptured varix originating from the posterior peritoneum extending to the anti-mesenteric border of the hepatic flexure of the colon. Ligation of the varix controlled the bleeding. The blood loss was replaced.

The immediate postoperative course was uneventful. On the sixth postoperative day the patient again developed hematemesis. Esophagoscopy revealed multiple bleeding varices. A celiac arteriogram showed areas of hemorrhage at the distal esophagus and the gastroesophageal junction. After conservative measures failed, an end-to-side portocaval shunt was performed on the sixteenth postoperative day. A 50 percent reduction of portal pressure was achieved. However, bleeding recurred one week later. Arteriography did not reveal the source of hemorrhage and showed that the shunt was patent. In addition a fistula between the hepatic artery and the hepatic vein was demonstrated (Figure 1). No contrast material was seen in the biliary tract. Review of the previous arteriogram revealed that the arteriovenous fistula was probably present before the shunt procedure. The

*This work is from the Washington (D.C.) Hospital Center where Dr. Doromal was Chief Resident in Surgery and Dr. Middleton is presently a surgical resident. Dr. Keshishian is Associate Professor of Surgery at George Washington University School of Medicine.



Figure 1 — Celiac axis arteriogram showing the arteriovenous fistula between the hepatic artery and the hepatic vein. This fistula is much larger than those seen in advanced hepatic cirrhosis.

patient later vomited, aspirated, and expired despite immediate recognition and treatment of the aspiration. The relatives refused an autopsy.

Discussion

Regardless of the etiology, massive intraperitoneal hemorrhage warrants immediate operative intervention because of the high mortality rate. The majority of these patients are poor operative risks and cannot withstand prolonged intra-abdominal bleeding.

The differential diagnosis of massive intraperitoneal hemorrhage in a cirrhotic patient includes ruptured spleen, perforated bleeding peptic ulcer, ruptured degenerating hepatoma and ruptured extraluminal varices. Bloor reported a 58-year-old patient who developed severe shock from a ruptured varix extending from a surgical scar to a loop of small intestine.¹ Other unusual sites of hemorrhage are from intraluminal varices producing massive melena.^{5, 9} Kreck reported a 40-year-old woman with portal hypertension who developed recurrent vaginal bleeding from varices in the vaginal vault.⁸ Rothchild reported a case of ruptured mesenteric varix. The patient died of generalized bleeding diathesis.¹⁵

The causes of hepatoportal arteriovenous fistula include needle biopsy,¹⁴ trauma,^{3, 4, 11, 16} familial hereditary telangiectasia⁷ and hepatic cirrhosis.^{12, 17, 20} Fistula of the hepatoportal vessels does not produce the same hemodynamic changes as those found proximal to the liver or

other systemic fistula. Mooney, *et al.* studying this phenomenon, reported establishing arteriovenous fistulae in the hind limbs of dogs and found that interposing the liver between the fistula and the heart abolished many expected hemodynamic effects. This phenomenon was thought to be due to the protective effect of the hepatic sinusoidal resistance.¹³

Arteriovenous fistula of the hepatoportal vessels produces anatomic changes in the liver: sclerosis of the portal radicles and increased portal collagen, which results in portal hypertension.¹⁸

In hepatic cirrhosis, numerous circulatory changes occur. Among them are various vascular shunts which are noted with increased frequency. The shunts are (1) extrahepatic communications between the portal venous system and the systemic circulation, (2) intrahepatic arterial — portal venous shunts and intrahepatic portal — hepatic venous shunts. Minute communications between hepatic arteries and portal veins and between portal and hepatic veins are believed to be formed by sinusoidal elements that persist after the hepatic cells atrophy and fibrosis forms.²⁰

A portocaval shunt is not the recommended treatment of choice, even in the presence of esophageal varices, in cases of extrahepatic arteriovenous fistulae not due to cirrhosis. Such a procedure creates a systemic fistula bypassing the protective sinusoidal structures of the liver and could result in cardiac failure.^{3, 6} Simple ligation of the involved artery is the treatment of choice in extrahepatic fistula. Small intrahepatic arteriovenous fistulae have been reported to close spontaneously. Large intrahepatic arteriovenous fistula can be effectively treated with hepatic lobectomy.^{3, 19}

The occurrence of arteriovenous fistula in hepatic cirrhosis has been established by pressure studies¹² and arteriograms.²⁰

As more and more hepatic arteriograms are performed in cirrhosis of the liver, the incidence of arteriovenous fistula will rise. Hemobilia, which sometimes occurs in traumatic arteriovenous fistula, has not been observed in cirrhotic patients.

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A case report of cecal herniation through the foramen of Winslow is reported with successful surgical reduction. Pertinent x-ray findings are presented. A unique aspect of this case is the apparent posterior location of the stomach on the erect lateral film of the abdomen.

Cecal Herniation Through the Foramen of Winslow

**Edward G. Moss, M.D. and
Kenneth H. Soll, M.D./Camden***

Internal hernias in the abdominal cavity are unusual and the most unusual are those through the foramen of Winslow. As of 1967, only 90 cases of herniation through the foramen of Winslow with a mortality rate of 49 percent had been reported. Three additional case reports since then have emphasized the radiologic findings^{2, 3}. Since this is such an unusual entity with

a high overall mortality rate^{1, 4}, it is felt that an additional case report is warranted.

Case Report

A 63-year-old female was admitted to the emergency room of the Burdette-Tomlin Memorial Hospital on the evening of August 6, 1972 with nausea, vomiting, and severe epigastric pain of several hours duration. She denied any previous upper gastrointestinal symptoms. On physical examination,



Figure 1 — An upper gastrointestinal series reveals a large collection of gas medial to the stomach



Figure 4 — A follow-up post-operative barium enema was normal

*Dr. Moss is associate radiologist and Dr. Soll is chief attending radiologist at Cooper Medical Center, Camden



Figure 2 — An erect lateral film of the abdomen shows a large collection of gas apparently anterior to the barium filled stomach

epigastric tenderness was elicited but bowel sounds were normal. The initial laboratory studies were not remarkable.

A x-ray of the abdomen in the supine position revealed a gas shadow in the middle part of the upper abdomen, medial to the gastric air shadow. An upper gastrointestinal series revealed the stomach to be intrinsically normal; there was a large collection of gas medial to the stomach displacing it toward the left (Figure 1). Also, the proximal duodenal loop was slightly to the left of its usual position. A lateral x-ray film of the abdomen in the erect position showed a large collection of air, apparently anterior to the stomach (Figure 2). It seemed to have haustral markings. A barium enema was then performed which showed the cecum to be distended and to be located in the mid abdomen (Figure 3). Thus, it was determined that the cecum was the gas shadow medial to the stomach. There also appeared to be a slight area of narrowing of the ascending colon as it approached the mid-abdomen.

Surgery was performed. The patient was found to have a very mobile cecum and ascending colon which had entered the foramen of Winslow so that the cecum was located in the left upper quadrant of the abdomen posterior to the stomach. It was reduced to its normal position and fastened in place in the right lower quadrant and an incidental appendectomy was performed. The patient made an uneventful recovery and was discharged in good condition. A follow-up barium enema study approximately two and one-half months later was normal (Figure 4).



Figure 3 — A supine film from a barium enema reveals that the cecum was the gas shadow medial to the stomach

Comment:

The following factors play a role in the occurrence of lesser sac herniations: (a) a long and mobile mesentery, (b) absence of fusion of the ascending colon to the parietal abdominal wall, (c) enlargement of the foramen of Winslow, and (d) increased intra-abdominal pressure.^{3, 5}

The usual radiologic features which aid in the diagnosis are: (a) a collection of gas, or gas and fluid, in the lesser sac displacing the stomach anteriorly and to the left. (b) barium enema study showing the collection of gas to be the cecum, (c) displacement of the 1st and 2nd portions of the duodenum to the left.³

An interesting finding in this case is the apparent posterior position of the stomach and anterior position of the cecum as seen on the erect film of the abdomen. The mesentery was noted to be long and the cecum unusually mobile. The apparent discrepancy appears to be due to the

stomach being displaced far to the left and then falling back away from the cecal hernia. This apparent posterior position of the stomach on the lateral view has not previously been reported.

Prompt surgical reduction of the hernia should considerably lower the previously reported mortality rate.¹

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Cooper Medical Center, Camden

Rheumatology—Sheldon D. Solomon, M.D.

Matching symptoms with the appropriate diseases:

- | | |
|---|------------------------------------|
| A. Difficulty swallowing, weight loss, and diarrhea. | 1. Temporal-arteritis. |
| B. Solitary coin lesion. | 2. Rheumatoid arthritis. |
| C. Fever, weight loss, hematuria, and hypertension. | 3. Saturnine gout. |
| D. Sudden onset of blindness associated with pain on chewing. | 4. Polyarteritis nodosa. |
| E. Wrist drop, anemia, and renal calculi. | 5. Progressive systemic sclerosis. |

A-5 — The system complex of difficulty swallowing, weight loss, and diarrhea would be compatible with Progressive Systemic Sclerosis. Seventy percent of patients with this disease have esophageal involvement manifested by dysphasia. A smaller percentage can often present with malabsorption syndrome with weight loss and diarrhea secondary to small bowel involvement.

B-2 — A solitary coin lesion can occasionally be the presenting manifestation of rheumatoid arthritis. Rheumatoid lung disease is usually seen in patients with the severe rheumatoid arthritis, but occasionally it could be an early manifestation. The manifestation of rheumatoid lung disease can include pulmonary nodules, fibrosis, and/or pleural effusion.

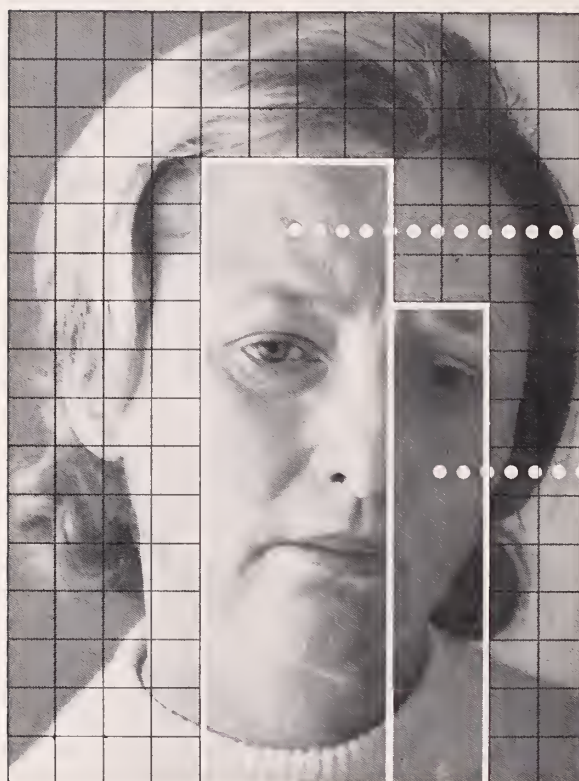
C-4 — Fever, weight loss, and hematuria can often be associated with patients who have polyarteritis nodosa. Fever and weight loss can be seen in over 75 percent of patients, while the renal manifestations can occur in up to one-third.

D-1 — Sudden blindness and pain on chewing can be seen in temporal arteritis. In this disease, both intracranial and extracranial blood vessels can be involved causing ischemia to the distal organs, i.e., blindness due to ophthalmic artery involvement and claudication of jaw muscles due to vasculitis of the external carotid artery and its branches.

E-3 — Wrist drop, anemia, and renal calculi can be seen in saturnine gout. This condition is often seen in patients living in the South who produce their own moonshine liquor. This contains a high content of lead and manifestations in addition to hyperuricemia and renal stones occur. Other manifestations of lead intoxication, in addition to renal calculi, secondary to hyperuricemia and renal stones, can be wrist drop and anemia.

*From "The Cooper Review" published by the Department of Medical Education, Cooper Medical Center, Camden, New Jersey, where Dr. Solomon is Chief Attending Rheumatologist.

Both often



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neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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with associated
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Aneurysmal dilatation of the pulmonary artery was present before birth in an infant with tetralogy of Fallot and rudimentary pulmonic valve, resulting in bronchial obstruction and retention of lung fluid. It is likely that aneurysm formation in this lesion was due to intrinsic abnormality of the vascular walls rather than to hemodynamic factors. The presence of severe respiratory embarrassment in neonates with this lesion is associated with a high mortality rate. A palliative operation described recently provides relief of bronchial obstruction by decompressing the posterior mediastinum.

Fallot's Tetralogy with Pulmonary Arterial Aneurysm*

O. Robert Levine, M.D., José R. Antillon, M.D., Barry Lauton, M.D. and James R. Marquis, M.D.

Fallot's tetralogy presents a wide clinical spectrum relating chiefly to the severity of right ventricular outflow obstruction. When accompanied by hypoplasia or aplasia of the pulmonic valve the clinical picture may be complicated by aneurysmal dilatation of the main and branch pulmonary arteries. This rare anomaly is recognized by a characteristic syndrome consisting of cyanosis, a to-and-fro murmur, and respiratory embarrassment due to bronchial compression. The case to be presented illustrates this syndrome in its most severe form. The lesion was fully expressed at birth, suggesting that pulmonary artery aneurysm formation was conditioned by a primary defect within the walls of the affected vessels rather than by hemodynamic factors.

Case Report

A male infant, the firstborn of healthy parents following an uncomplicated pregnancy and delivery, weighed 7 lbs. 5 ozs. at birth. From the moment of birth, he exhibited limpness,

cyanosis and severe respiratory distress, with retractions and a weak cry. Apgar scores were 2, 6 and 4 at 1, 5 and 10 minutes, respectively. Breath sounds were present over the left and absent over the right chest. A grade 4-5/6 "to-and-fro machinery-type" murmur was best heard over the right precordium. The liver edge was palpable 3 cm below the right costal margin. Blood gas determinations showed severe hypoxemia, hypercarbia, and acidosis (Table 1). Sodium bicarbonate was administered intravenously.



Figure 1 — Chest roentgenogram taken shortly after birth. The mediastinum is shifted into the right hemithorax. Aerated lung tissue is present at the right costophrenic angle. The left lung is distended, fluid-filled, and herniated into the right chest.

Table 1

Age	pH	Arterial blood gases		FI _O ₂
		PCO ₂ mmHg	PO ₂ mmHg	
1 hr	7.07	100	26	100 (mask)
7 hr	7.06	83	37	100 (endo. tube)
12 hr	7.17	64	30	100 (endo. tube)
24 hr	7.55	36	31	100 (endo. tube)
48 hr	7.53	30	31	100 (endo. tube)

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Figure 2 — Chest roentgenogram, age 3 days, showing clearing of fluid from left lung with persistent mediastinal shift. An endotracheal tube is present.

The initial chest roentgenogram (Figure 1) revealed shift of the mediastinum into the right hemithorax, a small area of aerated lung tissue visible at the right costophrenic angle, and a hyperinflated left lung which appeared homogeneously hazy, granular and reticular. The electrocardiogram showed right axis deviation and right ventricular hypertrophy.

Endotracheal intubation was carried out at 2½ hours of age and thereafter the patient required positive pressure ventilation with positive end-expiratory pressure in order to avoid severe hypercapnia. Arterial pO_2 never exceeded 43 mm Hg despite inspired oxygen fraction of 100 percent. The clinical course during the ensuing two days was complicated by right tension pneumothorax which was relieved by insertion of a chest tube, and by alkalotic tetany which required the administration of calcium and diazepam (Valium®).

The infant's general condition stabilized, but he remained cyanotic and respirator-dependent. Chest x-ray showed gradual clearing of the hazy left lung, which remained markedly hyperinflated and herniated into the right hemithorax (Figure 2). Aeration of the right lower lobe was apparent, and failure of full inflation of the right lung was attributed to compression by the emphysematous left lung. Rightward shift of the mediastinum and failure of expansion of the right lung persisted. On the third day, based on the clinical impression of lobar emphysema, a left thoracotomy was carried out. The salient findings were: (1) a markedly hyperinflated left lung, with perihilar subpleural blebs, (2) compression atelectasis of the right lung, (3) aneurysmal dilatation of the main and left pulmonary arteries. A left upper lobectomy was done, and following this procedure there was evidence of improved aeration of the right lung with shift of the mediastinum toward the left.

Selective right ventricular angiocardiography (Figure 3) on the fourth day revealed tetralogy of Fallot with aneurysmal dilatation of the main, right and left pulmonary arteries, and attenuation of the peripheral pulmonary arteries bilaterally.

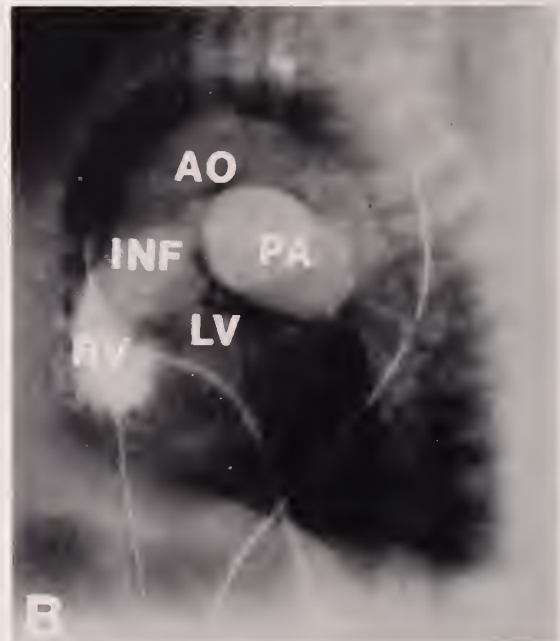


Figure 3 — Selective right ventricular angiocardiogram. A. Frontal view. B. Lateral view. Contrast material opacifies a normal-sized right ventricle (RV) and is shunted into the left ventricle (LV) and aorta (AO). The pulmonary infundibulum (INF) is wide and the valve annulus markedly restricted. The main, right and left pulmonary arteries (PA) are aneurysmally dilated, and their peripheral branches attenuated.

Subsequent chest roentgenograms showed progressive hyperinflation of the left lower lobe with rightward mediastinal shift. The clinical status deteriorated and the infant died on the 7th day of life.

The necropsy findings were similar to those previously reported¹⁻⁴ consisting of (1) a large ventricular septal defect with overriding aorta, (2) annular pulmonic stenosis with rudimentary valve tissue and an orifice diameter of 0.4 cm, (3) aneurysmal dilatation of the main pulmonary artery and its main right and left branches, (4) normal pulmonary arteries distal to the aneurysm, (5) a hypertrophied right ventricle and infundibulum, with normal cavity size, and (6) histological evidence of disorganization of the elastic fibers in the walls of the dilated pulmonary trunk. All remaining lobes of the lungs inflated readily and there were no intrinsic obstructing elements in the airways.

Discussion

This infant manifested extreme hypoxemia and severe respiratory distress from the moment of birth. The cardiovascular anomaly, demonstrated by angiocardiology and confirmed by necropsy, consisted of a severe form of Fallot's tetralogy associated with hypoplasia of the pulmonary valve ring and leaflets. Pulmonary regurgitation was superimposed on annular stenosis, as manifested by the "to-and-fro" murmur. However, because of the severity of the stenosis it is unlikely that regurgitant flow contributed significantly to right ventricular outflow obstruction. Instead, the blood gas data and the angiographic evidence of severe pulmonary hypoperfusion suggest that all but a small fraction of the systemic venous return was shunted through the ventricular septal defect into the aorta. This was chiefly responsible for the extreme arterial hypercarbia and hypoxemia present from birth. Normocarbia was restored only after endotracheal intubation and institution of positive-pressure ventilation with 100% oxygen and positive end-expiratory pressure, while arterial oxygen tension remained at 25-35 mm Hg. These findings reflect the additional influences of alveolar hypoventilation due to bronchial compression, and intrapulmonary shunting due to perfusion of atelectatic lung.

Respiratory problems resulting from bronchial compression dominated the clinical picture. Partial obstruction of the left mainstem bronchus produced marked overdistension of the left lung, with herniation and mediastinal shift into the right hemithorax. In addition, there was roentgenographic evidence of retention of fetal lung fluid, with slow resolution over the first three days of life. Similar changes have been described in congenital lobar emphysema, and have been cited as evidence that fetal lung fluid is in part mechanically expressed via the airways

during the birth process, with the remainder subject to gradual lymphatic removal.⁵⁻⁷

The pathogenesis of the aneurysmal dilatation of the central pulmonary arteries in this syndrome has been attributed to mechanical hemodynamic factors and to structural abnormality of the affected vascular walls.^{1-4, 8-11} Microscopic alterations in the medial layer of the pulmonary trunk and main pulmonary arteries have been described in some cases^{1-4, 10} but have been lacking in others.¹¹ Occurrence of the full-blown lesion at birth, as in the present case, suggests that post-natal hemodynamic changes are not etiologically significant.

Progressive dilatation of blood vessels occurs proximal to coarctation or branch stenosis, or distal to a discrete stenosis in response to physical forces associated with jet flow.^{12, 13} Although poststenotic vascular distension is uncommon in tetralogy of Fallot with infundibular pulmonic stenosis, aneurysmal dilatation is characteristically present when the same lesion is associated with rudimentary or absent pulmonary valve.⁹ Distension of the great arteries also occurs in association with regurgitant lesions due to the mechanical effects of increased stroke volume and pulse pressure. These changes are usually accompanied by dilatation of the affected ventricular chamber. Although the pulmonary arteries are usually enlarged in cases of isolated pulmonary regurgitation, aneurysm formation is uncommon.^{14, 15}

During fetal life right ventricular outflow is relatively low because of preferential shunting of inferior vena caval return across the foramen ovale into the left atrium. Due to a high pulmonary vascular resistance most of the right ventricular output is shunted into the aorta via the patent ductus arteriosus. As a result only a small fraction of the total cardiac output traverses the pulmonary vascular bed in the term fetus.¹⁶

The etiologic significance of valvular insufficiency for the development of pulmonary arterial aneurysm may be discounted in the present case because of absence of right ventricular dilatation (Figure 3). Aneurysm formation in response to annular stenosis is also unlikely, particularly in

the presence of a ventricular septal defect, because of the relatively low right ventricular output during fetal life. Normal fetal hemodynamics preclude significant left-to-right ductal shunting, and the clinical features of the present case provide no support for pulmonary artery distension on the basis of increased pulmonary blood flow.

Summary

The present case offers two lines of evidence suggesting that aneurysmal dilatation of the pulmonary arteries in this lesion is conditioned by an intrinsic defect in the affected vascular walls: (1) Presence of the aneurysm before birth, as attested to by the retention of lung fluid in the partially obstructed left lung, indicates that post-natal hemodynamic factors are not causative. (2) The etiologic significance of prenatal hemodynamics in formation of the pulmonary arterial aneurysm may be discounted on the basis of a low pulmonary blood flow before birth. Histological evidence of abnormal vascular architecture in the present and in previously reported cases suggests a primary defect in embryogenesis of the affected vascular walls.

Although this lesion is amenable to total surgical correction in older infants and children, the onset of respiratory symptoms in early infancy denotes a severe anomaly with extreme pulmonary artery distension, and a correspondingly poor prognosis.^{8, 17} Litwin and associates have recently described a palliative operation designed solely for the relief of respiratory obstruction. The right pulmonary artery is divided and the proximal end oversewn. A tubular prosthetic graft, positioned anterior to the aorta and superior vena cava, is sutured end-to-side to the anterior aspect of the main pulmonary artery, and to the distal end of the divided right pulmonary artery. This procedure, applicable to neonates, directly relieves obstruction of the right bronchus, and provides sufficient decompression of the posterior mediastinum to relieve left bronchial obstruction as well.¹⁸

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Report of the Task Force Assigned To Consider the Future of the New Jersey Hospital for Chest Diseases at Glen Gardner

Lee B. Reichman, M.D./Newark*

Tuberculosis is thought by most observers to be a romantic problem of the past. New drugs, new methods of treatment, and an improvement of social conditions have decreased the incidence of this disease and its complications.

Unfortunately, tuberculosis remains a major health problem for the State of New Jersey. In 1973, New Jersey ranked 19th among all states in terms of its new active case rate and 9th among all states in terms of total incidence. Tuberculosis is mainly an urban disease. Nationally, in 1973 Newark ranked first among the 58 cities of 250,000 or more population as to new active case rates. In the same year Jersey City ranked 15th. Nationally among the 95 cities of 100,000 to 250,000 population, Paterson ranked second, Trenton 6th, Camden 29th and Elizabeth 37th.

Some of the alarming high incidence of tuberculosis in New Jersey's urban centers can be attributed to the existence of ghetto conditions, but this alone does not account for the disproportionate concentration of cases in the State of New Jersey.

A recent study (Dildine and Burch: State and Local Tuberculosis Control in New Jersey: A Legal and Administrative Analysis of the Problem, Bureau of Government Research, Rutgers — the State University, March, 1974) (hereafter referred to as the Rutgers Report) suggests that the high tuberculosis rates in New Jersey may be due to numerous diverse factors: poor reporting, variable degrees of standards in running tuberculosis clinics, lack of follow-up, lack of coordination of services, varying organizational structures of tuberculosis control programs and out-dated laws. According to the Rutgers Report, underlying all the above seems to be the State Department of Health's sluggish response to deficiencies in local tuberculosis con-

trol programs. The Rutgers Report goes on to point out that "While the State does have the legal power to intervene to eliminate major deficiencies in local programs, the fact that it is unused leaves municipalities largely to their own preferences and devices in providing service to their tuberculosis patients." The Task Force thinks that the State's problem is lack of impact and authority in implementing tuberculosis control measures, and this arises from lack of resources.

On September 24, 1974 an Ad Hoc Joint Committee of the Sponsoring Agencies of the Rutgers Study (American Lung Association of New Jersey, New Jersey State Department of Health, and Rutgers University Bureau of Government Affairs) revised and rearranged the 10 recommendations of the Rutgers study to four major recommendations as follows:

1. All outdated tuberculosis control laws should be revised or repealed.
2. It is recommended that the State Health Commissioner be given, by statute, proper supervisory powers over all duly established local tuberculosis control programs, including the right to promulgate and enforce updated minimum performance standards and provide financial and technical assistance, and that tuberculosis control be reorganized to place operational responsibility at the appropriate municipal, county, or regional level.
3. General hospitals should be required to provide in-patient care of tuberculosis patients, and a more equitable and up-to-date program of

*Dr. Reichman was chairman of the group; other members of the Task Force were L. Fred Ayzajian, M.D., Aaron Chaves, M.D., Brian Collins, M.D., Phyllis Q. Edwards, M.D., Robert F. Johnston, M.D., Donald Kwalick, M.D., Dominic Mauriello, M.D., and John F. Marshall, M.D.

state financial aid should be adopted for all hospitals which supply adequate care of these in-patients.

4. Tuberculosis bacteriological examinations shall be performed by laboratories approved by the State Commissioner of Health.

As will be noted the Task Force recommendations take into account some of the major recommendations of the Ad Hoc Joint Committee and, we feel, provide a viable means for early implementation of them.

Methods and Findings

It is now widely accepted by the medical profession that tuberculosis patients should be hospitalized only on the basis of clinical conditions requiring acute in-hospital care and not solely because of their diagnosis. It is furthermore widely accepted that comprehensive out-patient care for tuberculosis patients is more successful and far less costly than long term hospitalization. Comprehensive out-patient care also has the benefit of keeping the patient in his community and thus improving his motivation to continue the two years of treatment necessary for cure.

Utilizing these standards, all the patients at the New Jersey Hospital for Chest Diseases were evaluated by members of the Task Force and staff on November 15, 1974.

The hospital staff had completed survey forms on each of the 173 patients indicating basic identification and demographic information; third party payment sources, source of referral, current classification and diagnosis; bacteriology examination results and current drug therapy.

The survey forms were reviewed and the patients placed in one of five categories. (Tables 1 and 2)

Table 1							
Patients Surveyed By Sex and Age							
	0-15	16-25	26-44	45-64	65+	Total	Average Age
Female	1	2	12	12	8	35	46.0
Male	0	6	33	64	35	138	52.2
Total	1	8	45	76	43	173	51.1
Medial Age: 53	Range: 8-86						

Table 2		
Survey Groups		
1. Patients with negative cultures, under 65 years of age	31	(17.9%)
2. Patients with negative cultures, over 65 years of age	12	(6.9%)
3. Patients with special medical problems	28	(16.2%)
4. Patients newly admitted, culture status pending	36	(20.8%)
5. Patients with positive bacteriology	66	(38.2%)
Total 173		

All the patients were visited by Task Force members to evaluate their ambulatory condition, ability to take care of personal needs, symptoms, and other concurrent diagnoses: alcoholism, addiction, chronic obstructive pulmonary disease, other chronic disease, behavioral problems, psychiatric problems. Appropriate notes were made on each survey form by a Task Force member.

The survey forms were again reviewed and each patient was further categorized according to the level of care needed for his (or her) *present* tuberculosis condition:

1. *Out-Patient Care* — 133 (76.9%) — These patients were fully ambulatory and did not require in-patient care by current standards, but required continued supervision in adequate out-patient facilities throughout the State until adequate anti-tuberculosis drug therapy is attained — usually 18 to 24 months.
2. *Nursing Home Care* — 28 (16.3%) — These patients were under tuberculosis treatment, not fully ambulatory, and could not adequately care for themselves. They did not require in-patient care in this hospital, but would require care in nursing homes or other long-term care facilities.
3. *Acute Hospital Care* — 2 (1.1%) — These patients were acutely ill with newly diagnosed or reactivated tuberculosis. Their acute hospital care could be provided in a general hospital that treats acutely ill patients of all kinds. Support services such as medical intensive care unit, coronary care unit, arterial blood gases, cardiac arrest team, and operating room facilities should be available for an acutely ill patient in a general hospital setting.
4. *Chronic Hospital Care* — 2 (1.1%) — These patients were primarily hospitalized for their

Table 3
Level of Care Required by Group

Group Number	Total	Out-Patient	Nursing Home	Psychiatric Hospital	Chronic Hospital	Acute Hospital
1.	31	28	1	1	1	
2.	12	4	8			
3.	28	11	12	2	1	2
4.	36	26	6	5		
5.	66	65	1			
Total	173	133 (76.9%)	28 (16.3%)	8 (4.6%)	2 (1.1%)	2 (1.1%)

chronic pulmonary disease condition. They require specialized support facilities such as a respiratory care unit and frequent blood gases, as well as constant use of respirator or oxygen, which should be available in chronic hospitals or other long-term facilities.

5. Psychiatric Hospital Care — 8 (4.6%) —

These patients pose psychiatric or behavioral problems and should be returned to the State or county institution from whence they came. Since tuberculosis is generally non-infectious approximately two weeks after the initiation of effective therapy, these patients should be briefly isolated at their hospital and returned to open wards for their anti-tuberculosis medication when non-infectious.

A question was raised as to the feasibility of treating tuberculous alcoholic patients as out-patients in lieu of hospitalization as a means of

ensuring drug ingestion. The Task Force feels that it has been amply proved by Dr. John Edsall at Harlem Hospital in New York, Dr. W. Paul Regan in Detroit, Dr. Francis Curry in San Francisco, and Dr. John Sbarbaro in Denver that a comprehensive clinic arrangement with field visit follow-up or supervised intermittent treatment at the clinic, daily or twice weekly, is extremely successful and far more economical than hospitalizing these patients.

It was noted that 64.4 percent of the patients came from four of New Jersey's largest counties in terms of population: Essex — 50 (28.9%), Hudson — 35 (20.2%), Union — 18 (10.4%), Mercer — 9 (5.2%). (See Table 4)

An analysis of third party payment sources (Medicaid, Medicare, Blue Cross/Blue Shield, medical insurance) is shown in Table 5.

Table 4
Level of Care Required By County

County	Out-Patient	Nursing Home	Psychiatric Hospital	Chronic Hospital	Acute Hospital	Total
Atlantic	11	2				13
Bergen						0
Burlington	1		1		1	3
Camden	3	1				4
Cape May	2	1				3
Cumberland						0
Essex	41	6	2	1		50
Gloucester	1					1
Hudson	28	4	2		1	35
Hunterdon	5					5
Mercer	7	1	1			9
Middlesex	1					1
Monmouth	1	2	1			4
Morris	7	2				9
Ocean	1	2				3
Passaic	2					2
Salem	2	2				4
Somerset	1	1				2
Sussex	1	1	1			3
Union	16	2				18
Warren	2	1		1		4
Total	133	28	8	2	2	173

Table 5
Third Party Payment Sources By Group

Group	3rd Party Payment Source	No 3rd Party Payment With Veterans Status	None	Total
1	17	4	10	31
2	9		3	12
3	23	1	4	28
4	21		15	36
5	40	9	17	66
Total	110 (63.5%)	14 (8.2%)	49 (28.3%)	173

Summary

Tuberculosis is still a serious public health problem in New Jersey. The development of general hospital treatment facilities and adequate out-patient facilities is needed to update the quality of care and control in this state and has, to a large extent, been impeded by the ready availability of the New Jersey Hospital for Chest Diseases for long-term care at state expense.

The New Jersey Hospital for Chest Diseases is a major focus of in-patient tuberculosis care in New Jersey. Any change in it will affect the entire state and its counties. No consideration of its future can be made without considering the entire state's tuberculosis control program under the State Department of Health. Therefore, the following recommendations are presented together as a unit. *It would be disastrous to implement any of these recommendations separately.*

Tuberculosis should be fully integrated into modern medical practice. The perpetuation of specialized tuberculosis hospitals is an anachronism.

A review of all the patients at the New Jersey Hospital for Chest Diseases on November 15, 1974 revealed that most did not require in-hospital care and could be discharged. Adequate out-patient facilities are not available to many patients in the state. Such facilities must be established where none exist.

The New Jersey Hospital for Chest Disease patients who do require hospital care could receive it in general hospitals near their homes. The remaining New Jersey Hospital for Chest

Disease patients have problems other than or in addition to tuberculosis which could be adequately and more economically cared for in long-term care facilities.

Tuberculosis in alcoholics is usually difficult to treat. However, it has been shown that such patients can be managed in properly designed and administered ambulatory care programs.

Recommendations

1. The New Jersey Hospital for Chest Diseases at Glen Gardner should be closed as a state chest disease hospital no later than June 30, 1975.
2. The tuberculosis control program of the State Department of Health should be revised and upgraded as pertains to in-patient and out-patient care and control. All outdated tuberculosis laws should be revised or repealed and the Commissioner of the State Department of Health be given, by statute, proper supervisory powers over all duly established local tuberculosis control programs including the right to promulgate and enforce up-to-date minimum performance standards, as well as to provide financing and technical assistance.
3. General hospital and long-term care facilities, including state institutions, should provide in-patient care for tuberculosis patients as needed. If such institutions refuse to so provide, licensure status should be subject to review and possible revocation.

Table 6
Patients Hospitalized in General Hospitals by County of Residence*

Beds needed on 10/21/74	388
Less beds required for patients with no status reports in 1974, but who are still listed as hospitalized	88
	300
Less beds for those at Glen Gardner not requiring acute or chronic hospitalization and those who could be transferred to nursing home	169
Beds needed on 11/15/74	131

*Based on the data that was gleaned from the survey forms at Glen Gardner (11/15/74) and a review of the State Health Department's monthly alphabetical index of tuberculosis cases.

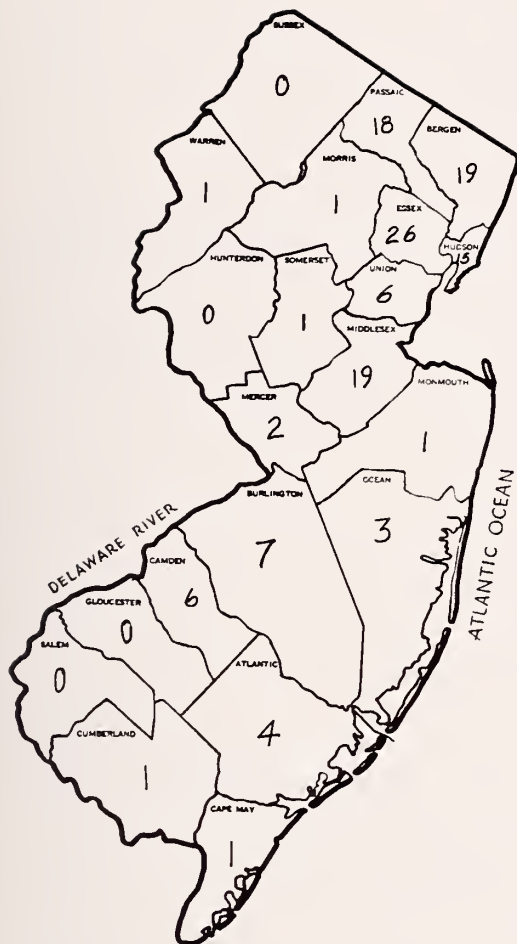


Figure — Tuberculosis patients requiring beds in general hospitals on a daily basis if Glen Gardner is closed — total: 131 (11/15/74)

4. Since modern tuberculosis treatment and control depend upon ambulatory services, these services must be initiated, augmented, and upgraded in all parts of the state. The out-patient treatment of tuberculosis should be expanded and improved in order to provide high quality care for patients in all parts of the state.

5. An equitable and up-to-date program of state financial aid should be adopted for all in- and out-patient facilities which supply adequate care for these patients. Such aid would be contingent upon prompt reporting and adherence to standards of performance as promulgated by the State Department of Health.

Table 7

Estimated Cost of Hospitalization

Number of Patients Hospitalized on a Daily Basis	131
Average Per Diem Rate*	113.50
Cost Per Year (131 x 365 = 47,815 x \$113.50)	\$5,427,003.00
Cost of Paying for Hospitalization of those Patients with no Third Party Payment Source	\$1,535,842.00
(Based on 28.3% of Total)	
75%	\$1,151,882.00
50%**	\$ 767,921.00

*Average per diem rate was calculated on the per diem rate in each county if one hospital in each county was used. The hospital chosen was one that had already treated TB patients.

**It is anticipated that existence of a strong comprehensive out-patient program monitored by the State Health Department will radically diminish the need for TB beds in general hospitals to at least 50% of the total.

Table 8

Projection of Out-Patient Costs

Cases on Drugs	2,500 x 12 visits = 30,000 visits x \$25.00/visit = \$750,000
Others (skin tests)*	17,500 x 2 visits = 35,000 visits x \$ 2.75/visit = 96,250
(x-rays)**	7,000 x 1 visit = 7,000 visits x \$15.00/visit = 105,000
(prev. therapy)†	2,800 x 12 visits = 33,600 visits x \$ 6.00/visit = 201,600
(final x-ray)††	2,800 x 1 visit = 2,800 visits x \$15.00/visit = 42,000
Totals	108,400 visits x \$11.25/visit = \$1,194,850

Subsidy Based on Cases on Treatment: State Health Department would pay 80% of cost of visits made by cases on drugs - 30,000 visits x \$20.00/visit = \$600,000 (The value of services by state personnel would be deducted.)

*Others needing services was calculated at 7 individuals per those cases on treatment (e.g. contacts, school tuberculin reactors, survey reactors, and so on.)

**Estimated that 40% would be tuberculin positive.

†Estimated that 40% would be placed on preventive therapy: One visit per month for INH plus one final x-ray.

††Includes cost of services provided by state personnel.

6. Based upon preliminary studies, the estimated additional costs to the State Department of Health will be \$1.3 million for fiscal year 1976. These monies would be provided by the transfer of \$1.3 million of the annual \$3.3 million budget of the New Jersey Hospital for Chest Diseases to the State Department of Health. It is imperative that these funds be provided or these recommendations cannot be implemented.

7. Because of the responsibility that will be assumed by the State Department of Health, an evaluation committee appointed by the State Health Commissioner from nominations by the

State Tuberculosis Advisory Council, and the American Lung Association of New Jersey should be constituted to meet periodically to review the performance of the State Health Department in its Tuberculosis Control Program and to make recommendations to the Health Commissioner on correcting deficiencies as they arise.

8. There should be a concerted educational effort on the part of the official and voluntary agencies, with the help of the media, to prepare the providers and consumers of health services to accept and participate in general hospital and community based diagnosis and treatment of tuberculosis in New Jersey.

Martland Hospital Unit, CMDNJ, Newark

Orthopedic Surgery — David Cooper, M.D.*

Tibial Plateau Fractures:

A rare complication of tibial plateau fractures is:

- (a) Peroneal neuropathy
- (b) Deep venous occlusion
- (c) Non-union
- (d) Infection following open reduction

Answer: (c) The large cancellous surface at the fracture site encourages bony union, and non-union has not been reported. Deep venous occlusion has occurred in 6 to 14 percent in some series.¹ Peroneal neuropathy may be caused by either operation or casting² and infection can occur in up to 12 percent of surgical cases.³

References

1. Foged J: Osteosynthesis of the tibial condyle. *Acta Chir Scand* 91:143, 1944.
2. Jakobsen A: Operative treatment of the lateral tibial condyle fractures. *Acta Orthop Scand* 23:34, 1953.
3. Barrington T, Dewar F: Tibial plateau fractures. *Can J Surg* 8:146, 1965.

*From "The Cooper Review" published by Cooper Medical Center, Camden, where Dr. Cooper is orthopedic resident.

An important associated lesion accompanying a lateral tibial plateau fracture is a:

- (a) Torn lateral collateral ligament
- (b) Torn medial meniscus
- (c) Popliteus tendon rupture
- (d) Torn medial collateral ligament

Answer: (d) The medial collateral ligament may rupture as a result of the deforming valgus stress producing the plateau fracture. This can be diagnosed by stress roentgenograms under anesthesia.¹

Treatment is controversial; surgical repair and closed methods have both been reported to give satisfactory results.² It is necessary to recognize and treat this entity in order to prevent later instability.³

References

1. Tibial condylar fractures. *J Bone Joint Surg* 49-A:1455, 1967.
2. Porter B: Crush fractures of the lateral tibial table. *J Bone Joint Surg* 52-B:676, 1970.
3. Reibel D, Wade P: Fractures of the tibial plateau. *J Trauma* 2:337, 1962.

NEW JERSEY DOCTORS' NOTEBOOK

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

With its resumption of full-scale activity, September is always an exhilarating time on campus. The reopening of classes last month at the College of Medicine and Dentistry of New Jersey was no exception.

Among other things, CMDNJ — New Jersey Medical School (Newark) welcomed its new dean on board. He is Vincent Lanzoni, Ph.D., M.D., an eminent teacher and researcher, who has given more than a decade of service to the medical, graduate, and graduate dental schools of Boston University. Most recently he was associate dean, chairman of the curriculum committee, and coordinator of a major educational program of the medical school there, and was active in both the teaching and research programs of the departments of pharmacology and medicine.

Before matriculating at Boston University's medical school, Dr. Lanzoni was a teacher and researcher under a National Institutes of Health-Heart Institute post-doctoral fellowship at Tufts University, where he was awarded a bachelor's degree in biochemistry and a doctorate in pharmacology. After receiving his medical degree in 1960, Dr. Lanzoni pursued postgraduate training in medicine during the next five years at the Boston City Hospital. He remained associated with that hospital as attending physician on the medical service.

His decade at Boston University ranged from developing and coordinating new undergraduate and graduate educational programs in the medical and dental schools to evolving educational programs in five Boston area hospitals affiliated with the university and conducting a graduate program in the sciences. His research in cardiovascular pharmacology and hypertension resulted in the development of a doctoral training program in that field.

This is surely a fitting time to welcome so dis-

tinguished a physician and educator to our midst. CMDNJ observed its fifth anniversary this year, and CMDNJ — New Jersey Medical School is looking forward to moving "across the street" to its new campus in the now not-too-distant future. Indeed, the move actually began in August with the relocation of our library to its own building on the new campus. With a capacity of 150,000 volumes and with 400 reader stations, it is New Jersey's major source of biomedical literature. Librarian Philip Rosenstein cordially invites your visit.

The new library is integral to the complex we call the CMDNJ — Academic Health Center, Newark. Situated at the site of the new campus toward 12th Avenue and Norfolk Street, it forms one flank of a large, three-sided plaza. The building opposite will soon be occupied by CMDNJ — New Jersey Dental School. Between the two is the basic sciences building, which is in advanced stages of construction.

Less advanced but well under way is CMDNJ — New Jersey Medical School's future teaching hospital, which will abut the basic-science building but face Bergen Street, away from the campus plaza. And on the far side of the hospital site, already close to occupancy, is a new Community Mental Health Center.

We speak of the individual buildings on this new, 45-acre, \$189-million campus, but they actually constitute a coordinated complex of interrelated and interconnected structures, designed to minimize duplication of facilities and utilities. For example, the final building on the grounds is the power plant. It will provide heating, air conditioning, and other services for all of the buildings. One day one will be able to enter the farthest building and proceed through wide passageways and corridors to any other. For those who prefer to walk out-of-doors, there will be broad, covered arcades.

Except for the library, this year's entering class at CMDNJ — New Jersey Medical School may not have the use of the new campus in its freshman year, but it certainly will well before it graduates. If schedules hold, this class may even

be present for the opening of the new hospital, whose teaching hospital role is now being filled by Martland Medical Center.

And so, as we welcome our new dean and our new library, we also welcome an entering class of 110 first-year students at CMDNJ — New Jersey Medical School, plus 29 transfer students. Nearly all are from New Jersey. The transfer students are being admitted as upperclassmen in CMDNJ's continuing program to bring Americans home from foreign medical schools. This — and the Fifth Pathway program based at our CMDNJ — Rutgers Medical School — is a significantly successful effort to make up for the acute scarcity of entering places, not only at CMDNJ but at medical and dental schools throughout the nation.

The 139 new enrollees at CMDNJ — New Jersey Medical School are part of a total of 326 new admissions to all of our degree-granting schools, including the CMDNJ — Graduate School of Biomedical Sciences, Newark. Total enrollment as the school year got under way was 1,078, up nearly 50 students from the preceding year.

Hippocrates — Larger Than Life

If you haven't yet done so, you might want to renew your acquaintance with Hippocrates the next time you are in the vicinity of our CMDNJ-Rutgers Medical School campus in Piscataway. A larger-than-life statue of the "father of medicine" stands at the entrance to the school where it was unveiled last Spring, the gift of Peter T. Sideris of Woodbridge, New Jersey. The statue, nine feet tall on a seven foot pedestal, was sculpted in white marble by Kostas N. Georgakas of Athens, Greece. The marble, originally a five-ton block, came from the same Greek mountain that supplied the Parthenon and the temples of the ancient Acropolis.

Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

In August, three of our PSROs added new Executive Directors: Area II, Passaic Valley PSRO, engaged Mr. John Riczko; Area VII, Central New Jersey PSRO, added Mr. Dennis Duffy, and in Area VIII, Southern New Jersey PSRO, Mr. Michael Trenn was added to the team. These are talented people, and they will cooperate with all concerned in their areas. The Executive Director has a difficult, demanding, and sensitive job. In addition to managerial skills, a considerable degree of knowledge, patience, and tact are called for. We are fortunate in that all the "executives" in New Jersey, including our own Tom Crane, possess these qualities in abundance. These are relatively new "billets" in the medical management field. There is a constant flow of information from multiple sources (and not always consistent). Correspondence, meetings, and the ever-demanding telephone consume large amounts of time. The confines of budget and clock must be adhered to. The challenges are multiple, and their responses to them are appreciated.

New Jersey was well represented at the Annual Meeting of the American Association of Foundations for Medical Care (AAFMC) and the American Association of Professional Standards Review Organizations (AAPSRO) held in San Francisco in August. NJFHCE is a member of both organizations, and we also have many individual members. Individual membership in the AAPSRO is something that many of you should consider. These organizations provide a united voice to governmental and other agencies in matters affecting medical care quality, delivery, and efficiency. Their staffs keep abreast of all pertinent developments, and there is strong representation to HEW and to the National Professional Standards Review Council. We will be glad to send information to those interested in AAFMC and/or AAPSRO. Your correspondent was elected to the Board of Directors of AAPSRO, due to the united actions of our New Jersey representatives with strong support from the New York delegates. We have been pleased to hear on several recent occasions that NJFHCE is regarded as one of the better Support Centers, and we appreciate the fact that New Jersey's representatives are well received.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. Recent reports in the *New York Times* and *New York Post* stated that Flagyl® has been shown to cause malignant tumors in mice and rats. Please provide information concerning same.

Metronidazole (Flagyl®) is a systemic trichomonicide and amebicide which has been used extensively since 1960, and has recently been shown to be active against various anaerobic bacteria, including organisms which demonstrated significant resistance to many antimicrobial agents.¹

In long-term studies, metronidazole has been reported to increase the incidence of lung tumors and malignant lymphomas in Swiss mice, the incidence of mammary tumors in female Sprague Dawley rats,² and the mutation rate in some strains of bacteria.³ For this reason, Ralph Nader's Health Research Group of Washington, D.C., urged the FDA "to take prompt action against the use of metronidazole (Flagyl®) for the treatment of trichomonas

vaginitis because the drug causes cancer, gene mutations, and birth defects." It must, however, be noted that there are no reports of metronidazole inducing tumors in humans.⁴

In conclusion, although to date there are no reports of metronidazole inducing tumors in humans, it has been shown to be carcinogenic in rodents and mutagenic in bacteria. Until this question of carcinoma is resolved, it appears that metronidazole should not be used in treating conditions which respond to other conventional therapy.

References

¹Tally F P *et al*: Metronidazole versus anaerobes. *Calif Med* 117:22-26 (December) 1972.

²Anon: *American Hospital Formulary Service*. American Society of Hospital Pharmacists, Washington, D.C., 8:32 1974.

³Anon: Is Flagyl® dangerous? *Med Let* 17:53-54 (June 20) 1975.

⁴Based on personal correspondence between Dr. Alberti of G. D. Searle & Co. and the writer.

2. Do you have reports of myocardial infarctions being associated with withdrawal of propranolol in patients with angina pectoris?

Propranolol (Inderal®) may be used in patients with moderate to severe angina pectoris who have not responded to conventional measures. Sudden withdrawal of propranolol from patients with stable angina pectoris may result in a syndrome which is manifested by marked increase in the severity and frequency of angina and, in some instances, myocardial infarction.^{1,2,3} Although this syndrome has been described in propranolol's labeling for the past several years, due to its seriousness and several recently published reports of its occurrence, the FDA has added the following box warning to propranolol's labeling:

"There have been reports of exacerbation of angina and myocardial infarction following abrupt discontinuance of propranolol. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed, the patient should be cautioned against interruption and cessation of therapy without the physician's advice. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in older patients given propranolol for other indications."

In a recent report by Alderman, *et al.*⁴ they found that six patients with stable exertional angina pectoris immediately developed unstable angina after cessation of propranolol therapy. The character and frequency of the pain episodes were significantly worse than those that the patients had experienced either before or during propranolol treatment. Four patients had acute coronary events (myocardial infarction in three and sudden death in one) after 2 to 21 days of continuing unstable angina. Two patients returned to their usual clinical state when propranolol therapy was recommenced. All patients had moderately severe angina before treatment and had shown excellent clinical responses to propranolol therapy.

Olsen, *et al.*,⁵ in a double-blind study evaluated the effects of sudden propranolol withdrawal in 20 patients with coronary artery disease and severe angina pectoris who were receiving

propranolol, 160 — 320 mg. per day, for six to eight consecutive weeks. Within two weeks after discontinuing propranolol, 12 patients showed an increase in weekly angina attacks from seven to eleven, three patients developed unstable angina and were hospitalized, one patient was hospitalized with ventricular tachycardia, one patient had a massive myocardial infarction and subsequently died, and one patient suddenly died.

In conclusion, the true incidence of this syndrome is not known, and to date angina has not been reported following withdrawal of propranolol from patients treated for conditions other than angina pectoris.⁶ However, when discontinuance of propranolol is planned, the dosage should be gradually reduced and the patient carefully monitored. The patient should be cautioned against interruption and cessation of therapy without the physician's advice.

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¹Slome R: Withdrawal of propranolol and myocardial infarction. *Lancet* 1:156 (January 20) 1973.

²Nellen M: Withdrawal of propranolol and myocardial infarction. *Lancet* 1:558 (May 12) 1973.

³Diaz R G *et al*: Withdrawal of propranolol and myocardial infarction. *Lancet* 1:1068 (May 12) 1973.

⁴Alderman E L *et al*: Coronary artery syndromes after sudden propranolol withdrawal. *Ann Intern Med* 81:625-627 (November) 1974.

⁵Olson H G *et al*: The propranolol withdrawal rebound phenomenon: Acute and catastrophic exacerbation of symptoms and death following the abrupt cessation of large doses of propranolol in coronary artery disease. *Am J Cardiol* 35:162 (January) 1975.

⁶Anon: Sudden withdrawal of propranolol dangerous. FDA drug bulletin, Dept. Health, Education and Welfare, Rockville, Maryland 5:6 (April-June) 1975.

3. What is the recommended influenza vaccine for the 1975-1976 season? Is it different from that available last year? What is the recommended schedule for vaccination?

The Bureau of Biologics, Food and Drug Administration, reviews influenza vaccine formulation regularly and recommends reformulation with contemporary antigens when indicated. Influenza virus vaccine, bivalent immunizing antigen, for 1975-76 differs from the 1974-75 influenza vaccine in the A influenza virus component. The 1975-76 vaccine contains no less than 1200 CCA units per human dose (0.5 ml.) in the recommended ration of 350 CCA units of the A influenza virus component representative of A/Port Chalmers/1/73 (H3N2), 350 CCA units of the A influenza virus component representative of A/Scotland/840/74 (H3N2) and 500 CCA units of the B influenza virus component representative of B/Hong Kong/5/72.¹

For 1974-75, the vaccine contained in each adult dose (0.5 ml) not less than 1200 chick cell agglutinating (CCA) units of antigen in the following proportion: 700 CCA units of a type A strain comparable to the prototype, A/Port Chalmers/1/73 (H3N2) and 500 units of a type B strain, B/Hong Kong/5/72.²

Influenza control through widespread vaccination is not currently a public health objective, but the Advisory Com-

mittee on Immunization Procedures of the U.S. Public Health Service recommends seasonal immunization for persons in the following categories: (a) persons suffering from chronic health problems such as rheumatic heart disease (especially with mitral stenosis), other cardiovascular disorders such as arteriosclerotic heart disease and hypertension (especially those with evidence of frank or incipient cardiac insufficiency), chronic bronchopulmonary disease (e.g., chronic asthma, chronic bronchitis, bronchiectasis, pulmonary emphysema, pulmonary tuberculosis), chronic renal disease, patients with diabetes mellitus and other chronic metabolic disorders and patients with Addison's disease; (b) patients residing in nursing homes, chronic disease hospitals, or in other such environments should be considered at particular risk since the living arrangements may allow greater spread of disease if an outbreak is established; (c) older age groups, i.e., persons over 45, and particularly those over 65. In addition, seasonal vaccination may be advisable, when epidemic influenza is forecast, for those groups providing essential community services, and who, through their occupations are exposed to high-risk situations: (a) hospital and other health service personnel; (b) public safety personnel.¹

The primary series of influenza virus vaccine, bivalent, has traditionally been two doses given at an interval of approximately two months. In 1973 the Advisory Committee on Immunization Practices advised that, based on preliminary data, the second dose provides little additional benefit and that it is reasonable to give a single dose of vaccine for either primary or annual booster vaccination. In either dosage regimen, vaccination should be completed by mid-November. The dose for an adult or child over 10 years of age is 0.5 ml. Fractional doses for primary immunization may be administered according to the following schedule: 1. Children 3 months to 6 years of age; two injections of 0.05 to 0.1 ml. each, one to two weeks apart, followed by a third dose of 0.05 to 0.1 ml. two months later. 2. Children between 6 and 10 years of age: two injections of 0.25 ml. each, given at least two months apart. A single booster injection at the dosage volumes recommended above may be administered to infants and children who have been vaccinated previously.¹

References

¹Anon: New formulation, *Pharm Index* 17:10-11 (July) 1975.

²Anon: Recommendation of the Public Health Service Advisory Committee on Immunization Practices, *Morbidity and Mortality Weekly Reports* 23:215 (June 15) 1974.

Physicians' Relief Fund

The Physicians' Relief Fund of The Medical Society of New Jersey is available to members of MSNJ in need of financial assistance in time of emergency or catastrophe. Applications are made through your county medical society—write or call the Secretary or the Executive Secretary for information.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY — Socorro D. Tamase, M.D., 225 South Crandall, Los Angeles, California 90057. Santo Tomas (Philippines) 1956. Board eligible. Group, solo, partnership, or hospital. Available.

Tser-Fu Huang, M.D., 32-46 69th Street, Woodside, New York 11377. Kaohsiung (Taiwan) 1969. Board eligible. Group or partnership. Available July, 1975.

DERMATOLOGY — Robert Schneider, M.D., 1945-16 Eastchester Road, Bronx, New York 10461. Brussels 1971. Board eligible. Solo, partnership, or group. Available.

FAMILY MEDICINE — Robert J. Breiman, M.D., 7801 NE 4th Court, Apt. S14, Miami, Florida 33138. University of Rochester 1973. Board certified. Group or partnership. Available June 1976.

GENERAL PRACTICE — Leonard S. Spoto, Jr., M.D., 1929 Sioux, Glendale, Arizona 85307. Wake Forest 1971. Group (no OB). Available July 1976.

Nellie Lee, M.D., 175 Hobart Street, Ridgely Park, New Jersey 07660. Far Eastern (Philippines) 1966. Subspecialty, cardiology. Board certified. Group, partnership, clinic, or solo. Available.

Leslie C. Feigin, M.D., 361 Park Ave, Apt. B-2, Orange, New Jersey 07050. CMDNJ 1973. Board eligible. Group or partnership in northern New Jersey. Available July 1976.

Ishwar V. Thakkar, M.D., 1926 West Harrison Street, Apt. 1110, Chicago 60612. Baroda (India) 1970. Subspecialty endocrinology. Board eligible. Group, associate with teaching hospital. Available July 1976.

NEUROLOGY — Muhammad Aslam, M.D., Mayfair Apts., A-2, May Drive, Schuylkill Haven, Pennsylvania 17972. Nishtar (Pakistan) 1967. Board eligible. Solo or associate. Available June 1975.

Harry L. Bremer, M.D., 3005 Scarborough Road, Cleveland Heights, Ohio 44118. Hahnemann 1971. Board eligible. Partnership. Available July 1976.

OBSTETRICS AND GYNECOLOGY — Chia Shereng Shu, M.D., 1564 St. Johns Place, Brooklyn, New York 11213. Taipei (Taiwan) 1968. Board eligible. Solo, group, or partnership. Available.

Lyle J. Breitkopf, M.D., 519 Maitland Avenue, Teaneck 07666. SUNY (Downstate) 1960. Board certified. Academic position (full-time) or group practice. Available.

Murray R. Master, M.D., Box 155, Barnes Hospital, St. Louis, Missouri 63110. Pennsylvania State 1973. Board eligible. Group or partnership. Available July 1976.

OPHTHALMOLOGY — Ronald S. Lorfel, M.D., 1505 Vicksburg St., Belleville, Illinois 62221. Wayne State University 1970. Board eligible. Solo, associate, or group. Available July 1976.

ORTHOPEDIC SURGERY — Ira Spar, M.D., 26 Allston Street, Apt. 1, Allston, Massachusetts 02134. George Washington 1968. Board eligible. Group, partnership, or hospital. Available.

Ihwan Kim, M.D. 1935-16-C, Eastchester Road, Bronx, New York 10461. Seoul (Korea) 1969. Solo or group. Available July 1976.

PATHOLOGY — M. Netto, M.D., 125 Heather Drive, Rochester, New York 14625. Madras (India) 1962. Board certified. Solo, group, associate, or hospital. Available September 1975.

PEDIATRICS — Surendra C. Sheth, M.D., 85-20 160th Street, Jamaica, New York 11432. Baroda (India) 1970. Board eligible. Solo, partnership, hospital. Available.

John Motley, M.D., 103 Poplar Lane, Lexington Park, Maryland 20653. Jefferson 1971. Board eligible. Group or partnership (willing to purchase). Available July 1976. Telephone (301) 862-3525

SURGERY — Allen W. Leadbetter, M.D., 1930 Planters Drive, Charleston, South Carolina 29407. University of Maryland 1969. Board eligible. Solo, partnership, or group. Available summer 1976.

Yusooff T. Allian, M.D., 26710 Golfview Rd., Dearborn Heights, Michigan 48127. Far Eastern (Philippines) 1967. Subspecialty, cardiothoracic surgery. Board certified in general surgery. Group, partnership, association, or solo. Available July 1976.

Achyutananda Roy, M.D., 5601 Boulevard East, Apt. 20-I, West New York, New Jersey 07093. Calcutta (India) 1961. Board certified. Group, partnership, or solo. Available.

Sheldon Kneller, M.D., Box 542, Martin Army Hospital, Fort Benning, Georgia 31905. Einstein (NY) 1968. Subspecialty, vascular surgery. Board eligible. Group or partnership. Available August 1976.

Shuban K. Moza, M.D., 1819 Williamsbridge Road, Apt. 2-A, Bronx, New York 10461. Kashmir (India) 1965. Board eligible. Group or partnership. Available.

UROLOGY — Harvey Mannes, M.D., 6916 Sprucewood Drive, Lawton, Oklahoma 73501. Jefferson 1968. Board eligible. Association leading to partnership or multispecialty group. Available July 1976.

Jonathan N. Goodson, M.D., 350 East 17th Street, Apt. 12-E, New York 10003. Georgetown 1971. Group, partnership, solo. Available June 1976.

1975-1976

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R. Winfield Betts, M.D., *Vice-Chairman* Medford
Clifford B. Blasi, M.D. Sea Girt
Charles P. Campbell, M.D. Hackensack
William A. Dwyer, Jr., M.D. Paterson
John A. Flood, Jr., M.D. Trenton
Christine E. Haycock, M.D. Newark
Dorson S. Mills, M.D. Elmer
Daniel J. O'Regan, M.D. Jersey City
Frank R. Schell, M.D. Wayne
Rudolph E. Schwaeble, M.D. Mendham
Michael D. Yablonski, M.D. Hackensack

Long Range Planning and Development

William J. D'Elia, M.D., (1976)
Chairman Spring Lake
Alfred A. Alessi, M.D. (1976) Hackensack
H. Oliver Brown, M.D. (1976) Westfield
Leon C. Edwards, M.D. (1976) Bedminster
Edward P. Healey, M.D. (1976) Clifton
Philip J. LoPresti, M.D. (1976) Haddon Heights
Bernard Robins, M.D. Springfield
Benjamin Wolfson, M.D. (1976) Woodbury

Medicine and Religion

John J. Bedrick, M.D., *Chairman* Bayonne
Reynold E. Burch, M.D. Newark
Charles H. Calvin, M.D. Edison
John S. Madara, M.D. Salem
Thomas H. McGlade, M.D. Camden
Watson E. Neiman, M.D. Cinnaminson
Edward W. Verner, M.D. Newark

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* Vineland
Albert F. Moriconi, M.D. Trenton
Emanuel M. Satulsky, M.D. Elizabeth

210th Annual Meeting

June 4-8, 1976

Cherry Hill Hyatt House

1975-1976

Special Committees and Liaison Representatives

Academy of Medicine of New Jersey

- (1) Board of Trustees/Liaison Committee
(Liaison requested by Academy — 6/19/66)
Edward G. Bourns, M.D. Jamesburg
James A. Rogers, M.D. Paterson
Howard D. Slobodien, M.D. Perth Amboy
- (2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy — 11/15/64)
Arthur Bernstein, M.D., *Chairman*,
Committee on Medical Education Maplewood
Frank C. Snope, M.D., *Vice Chairman*,
Committee on Medical Education Flemington

Aging, Children, and Youth, Women's Auxillary Committee on

(Liaison requested by MSNJ's Woman's Auxiliary — 11/19/72)
James A. Rogers, M.D. Paterson

American Medical Association-Education Research Foundation

(Liaison requested by AMA-10/7/51)
William Greifinger, M.D., *Chairman, Committee on Medical Student Loan Fund* Belleville

Audit Review Committee (1974-1975 Audit)

(Appointed annually by Board to review previous year's audit)
Louis F. Albright, M.D., *Chairman* Spring Lake
Edward G. Bourns, M.D. Jamesburg
Matthew E. Boylan, M.D. Avon-by-the-Sea
Charles L. Cuniff, M.D. Jersey City
William J. D'Elia, M.D. Spring Lake
Samuel J. Lloyd, M.D. Trenton
Consultants:
Rudolph C. Gering, M.D., *Treasurer* Trenton
I. Edward Ornaf, M.D., *Chairman, Committee on Finance and Budget* Cherry Hill

Bicentennial Celebration, Committee on National

(Established by Board of Trustees 7/19/70 to investigate the possibility of MSNJ's participation in the National Bicentennial Celebration in 1976)
Morris H. Saffron, M.D., *Chairman* Passaic
David R. Brewer, Jr., M.D. Mullica Hill
Peter J. Guthorn, M.D. Neptune City
Fred B. Rogers, M.D. Trenton

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association 4/25/69)
Frank Campo, M.D. Trenton

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP — 4/16/60)
James S. Todd, M.D., *Chairman*,
Board of Trustees Ridgewood
John J. McGuire, M.D., *President* South Orange
Mr. Vincent A. Maressa, *Executive Director* ... Trenton
Equal representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Institutional Trustees, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)
Frank J. Hughes, M.D. (1979) Gloucester

Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing — 11/21/65)
Henry J. Mineur, M.D. Cranford

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety — 9/61)
Board of Trustees (Reaffirmed by Board of Trustees 6/3/75)

Cordloc Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety — 9/17/61 — appointed by Director of Motor Vehicles)
Harry A. Kaplan, M.D. Trenton
James G. Kehler, M.D. Woodbury
John C. Wood, M.D. Trenton

Community Medicine Advisory Council

(MSNJ representation requested by Richard J. Cross, M.D., CMDNJ at Rutgers — 12/20/70)
Arthur Bernstein, M.D. Maplewood
Victor H. Boogdanian, M.D. New Brunswick

Comprehensive Health Planning Agency

(Liaison requested by the Comprehensive Health Planning Agency — 12/16/69)
Nicholas E. Marchione, M.D., *State Health Planning Council* Vineland
Irving P. Borsher, M.D., *Health Care Costs Committee* Newark
Arthur Bernstein, M.D., *Medicaid Committee* Maplewood
James A. Rogers, M.D., *Medical Education Facilities Committee* Paterson

Crippled Children Commission, State

(Appointed by Governor for 5-year term)
Harry W. Fullerton, Jr., M.D. Carney's Point

Delaware Valley Regional Medical Program

(Established at invitation of University City Science Center — 12/65)
Sherman Garrison, M.D. Bridgeton

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP — 8/21/60 — Quorum: 4 members)
1st District —
Ralph M. L. Buchanan, M.D.,
Chairman Phillipsburg
Charles I. Nadel, M.D. Irvington
2nd District —
John J. Bedrick, M.D. Bayonne
Robert A. Cosgrove, M.D. Jersey City
3rd District —
John S. VanMater, M.D. New Brunswick
John A. Kinzel, M.D. Trenton
4th District —
John C. Clark, M.D. Asbury Park
Frank J. Hughes, M.D. Gloucester
5th District —
Don B. Weems, Jr., M.D. Wenonah
Nicholas E. Marchione, M.D. Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education — 9/21/58)
Glenn P. Lambert, M.D., *Chairman, Special Committee on Child Health* Flemington

Electrical Safety and Maintenance Program, Board of Advisors to the

(MSNJ representation requested by New Jersey Hospital Association — 12/1/72)
MSNJ's representative will work with the Association of Hospital Engineers to develop a safety code for New Jersey hospitals.
Bernard M. Schnur, M.D. Trenton

Emotionally Disturbed Child, Advisory Council to Department of Education

(Liaison requested by Department of Education — 10/28/68)
William J. Farley, M.D. Brielle

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles — 7/29/66)
J. Berkeley Gordon, M.D. Rumson

Executive Committee

(Provided in the Bylaws, Chapter VI, Section 5 (b))
John J. McGuire, M.D., *President (Chairman)* South Orange
John S. Madara, M.D., *President-Elect* Salem
Frank R. Begen, M.D., *First Vice-President* Teaneck
Charles S. Krueger, M.D., *Second Vice-President* Mount Holly
James S. Todd, M.D., *Chairman of the Board of Trustees* Ridgewood

Health Careers Service, New Jersey

(Physician representation established by Board of Trustees 7/20/69)
Karl T. Franzoni, M.D. Trenton

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service — 7/19/64)
Presidents of Component Societies

Health Insurance Conference

(Committee established at request of Health Insurance Council — 3/24/57)
Arthur Bernstein, M.D., *Secretary (Chairman)* Maplewood
John J. McGuire, M.D., *President* South Orange
John S. Madara, M.D., *President-Elect* Salem
Frank R. Begen, M.D., *First Vice-President* Teaneck
Charles S. Krueger, M.D., *Second Vice-President* Mount Holly
Mr. Vincent A. Maressa, *Executive Director* ... Trenton

Historian-Archivist

(Created at the suggestion of the Executive Director — 1/13/57)
Morris H. Saffron, M.D. (Appointed 5/67) Passaic

Home Health Agencies, State Committee to Develop Standards for Licensure of

(MSNJ representation requested by the Secretary of the Licensure Committee of the New Jersey Department of Health — 10/15/72)
David Eckstein, M.D. Trenton

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital Association — 12/17/67)
John S. Madara, M.D. Salem

Hospital Advisory Council, State Department of Health

(Appointed by the Commissioner of Health for an indefinite term)
Nicholas E. Marchione, M.D. Vineland

House Maintenance, Staff Policies and Personnel Relations

(Special Committee created by Board of Trustees — 9/21/58)
John J. McGuire, M.D., *President (Chairman)* South Orange
John S. Madara, M.D., *President-Elect* Salem
Arthur Bernstein, M.D., *Secretary* Maplewood
Rudolph C. Gering, M.D., *Treasurer* Trenton
James S. Todd, M.D., *Chairman, Board of Trustees* Ridgewood
I. Edward Orna, M.D., *Chairman, Committee on Finance and Budget* Cherry Hill
Mr. Vincent A. Maressa, *Executive Director* ... Trenton

Industrial Safety Board, New Jersey

(Appointed by the Governor — 8/71)
Delma W. Caldwell, M.D. Linden

JEMPAC, Conference Committee with

(Established at request of JEMPAC — 6/25/67)
Meyer L. Abrams, M.D., *Chairman, Council on Legislation* Willingboro
Robert E. Fullilove, Jr., M.D., *Chairman, Council on Medical Services* Newark
Charles S. Krueger, M.D., *Second Vice-President* Mount Holly

Judiciary and Bar, Conference Committee on Inter-Relations with the

(Established at invitation of Supreme Court — 11/17/63)
John J. McGuire, M.D., *President* South Orange
John S. Madara, M.D., *President-Elect* Salem
Frank R. Begen, M.D., *First Vice-President* Teaneck
Charles S. Krueger, M.D., *Second Vice-President* Mount Holly
James S. Todd, M.D., *Chairman, Board of Trustees* Ridgewood
Arthur Bernstein, M.D., *Secretary* Maplewood
Rudolph C. Gering, M.D., *Treasurer* Trenton
Meyer L. Abrams, M.D., *Chairman, Council on Legislation* Willingboro
Paul J. Kreutz, M.D., *Chairman, Committee on Medical Defense and Insurance* Elizabeth
William J. D'Elia, M.D. Spring Lake
James A. Rogers, M.D. Paterson

Emanuel M. Satulsky, M.D. Elizabeth
 Samuel J. Lloyd, M.D. Trenton
 Nicholas E. Marchione, M.D. Vineland
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 Mr. Joseph C. Lucci, *Executive Assistant* Trenton
 Equal representation from:
 Supreme Court Committee on Relations with the
 Medical Profession

Legislation

- (1) Federal Keymen
 (Mechanism established by MSNJ—4/4/54—to serve
 as official intermediaries between MSNJ and the Federal
 legislators)
 15 Congressional District Keymen
 1 Senatorial Keyman
- (2) State Keymen
 (Mechanism established by MSNJ—7/13/52)
 Keymen in 15 Legislative Districts/21 Component
 Societies

Medicaid, Negotiating Committee For

(Established by Board of Trustees to work with the State
 Medicaid Commission—12/22/68)
 John J. McGuire, M.D., *President* South Orange
 John S. Madara, M.D., *President-Elect* Salem
 Robert E. Fullilove, Jr., M.D., *Chairman*,
Council on Medical Services Newark

Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the request
 of the Department of Institutions and Agencies. The func-
 tion of the Committee will be to act upon inquiries and/or
 complaints originating either with the administrators of the
 Medicaid Program or with physicians serving under the
 program.)
 1st District —
 Nicholas A. Bertha, M.D. Wharton
 2nd District —
 Ambrose P. Boyle, Jr., M.D. Fort Lee
 3rd District —
 Rudolph C. Gering, M.D. Trenton
 4th District —
 Emanuel Abraham, M.D. Asbury Park
 5th District —
 Jesse Carll, IV, M.D. Bridgeton

Medicaid Program, Medical Advisory Committee to the

(Appointment of four representatives requested by
 Department of Institutions and Agencies — 6/12/69)
 Donald P. Burt, M.D. Morristown
 Arthur C. Dietrick, M.D. Mount Holly
 John D. Franzoni, M.D. Trenton
 Leo J. Kelly, Jr., M.D. South Orange

Medical Assistance Advisory Council

(Established at invitation of State Medicaid Commission
 — Board action 4/20/69)
 A. Guy Campo, M.D. Westville
 Anthony P. DeSpirito, M.D. Asbury Park

Medical Assistants, (State of New Jersey) American Association of

(Liaison requested by Association — 9/15/63)
 William J. D'Elia, M.D. Spring Lake

Medical Education of New Jersey, Office of Continuing

(Liaison requested by College of Medicine and
 Dentistry of New Jersey — 4/20/72)
 John F. Kustrup, M.D. Trenton
 Arthur Bernstein, M.D. (alternate) Maplewood

Medical-Hospital-Nursing Conference (Tri-Partite)

(Liaison established by MSNJ — 1/13/57)
 John J. McGuire, M.D., *President* South Orange
 John S. Madara, M.D., *President-Elect* Salem
 James A. Rogers, M.D., *Immediate*
Past-President Paterson
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 Equal representation from:
 New Jersey Hospital Association
 New Jersey State Nurses' Association

Medical Liaison Committees

(High-level conference groups for discussion and
 consideration of items of mutual interest)
 John J. McGuire, M.D., *President* South Orange
 John S. Madara, M.D., *President-Elect* Salem
 James A. Rogers, M.D., *Immediate*
Past-President Paterson
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 (Where number of representatives from other organi-
 zation is larger than number of MSNJ representatives, the
 latter will be increased from the Presidential Officers to
 equal the former.)
 (1) Medical-Dental
 (Liaison requested by the Dental Society — 6/10/51)
 (2) Medical-Hospital
 (Liaison established by MSNJ — 10/25/53)
 (3) Medical-Legal
 (Liaison established by MSNJ — 10/25/53)
 (4) Medical-Nursing
 (Liaison established by MSNJ — 4/4/54)
 (5) Medical-Osteopathic
 (Liaison requested by Osteopathic Association —
 9/17/61)
 (6) Medical-Pharmaceutical
 (Liaison established by MSNJ — 7/26/53)

Medical-Surgical Plan Board of Trustees

(Provided in MSP Bylaws)
 John J. McGuire, M.D., *President* South Orange

Medicare Peer Review Committee

(Established by Board of Trustees 12/20/70 at request of
 fiscal intermediary. Committee will review and evaluate
 claims involving questions of overutilization under
 Medicare. Composition of committee includes six groups of
 three members each in the fields of general practice, general
 surgery, orthopedic surgery, internal medicine, ophthal-
 mology, and urology.)

Membership Directory

(Special committee established by Board — 11/19/61)
 Arthur Bernstein, M.D., *Chairman* Maplewood
 Matthew E. Boylan, M.D. Avon-By-The-Sea
 William Greifinger, M.D. Belleville
 Daniel B. Roth, M.D. Teaneck
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 Mr. Robert H. Lambert, *Bs. and Fin. Mgr.* Trenton

Membership Inquiry and Complaint Mechanism

(Established at the 12/10/72 Special Session of the House
 of Delegates to deal more effectively with third party in-
 surance carriers and government medical programs as they
 affect the practices of the membership.)

Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D. Passaic
 Donald P. Burt, M.D. Morristown
 Arthur C. Dietrick, M.D. Mount Holly

Karl T. Franzoni, M.D. Trenton
James E. George, M.D. Westville

Membership Inquiry and Complaint Committee with Medicare

Alfred A. Alessi, M.D. Oradell
William H. Coleman, M.D. Trenton
Richard H. DuPree, M.D. Woodbury
Andrew G. Hudacek, M.D. Morristown
Joseph W. Schauer, Jr., M.D. Farmingdale

Membership Inquiry and Complaint Committee with Medicaid

John J. Crosby, Jr., M.D. Jersey City
Michael J. Doyle, M.D. Neptune
Armando F. Goracci, M.D. Woodbury
Frederick J. Knocke, M.D. Readington
Robert E. McNamara, M.D. Newark

Membership Inquiry and Complaint Committee with Other Carriers

Melvin J. Andrews, M.D. Cherry Hill
Emanuel M. Satulsky, M.D. Elizabeth
Howard D. Slobodien, M.D. Perth Amboy
Robert A. Weinstein, M.D. Newton
Carl Minitti, M.D. Gibbstown

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter — 1/26/60)
Edward A. Wolfson, M.D. Glen Rock

**Nurse Pediatrician or Pediatric Nurse,
Advisory Council on the**

(Liaison established by the Board of Trustees — 2/27/72
— at the request of Rutgers University)
Harold L. Colburn, Jr., M.D. Moorestown

**Nurses' Association, Joint Practice Committee with the
New Jersey State**

(Established by Board of Trustees — 7/16/72 — to clarify
roles and functions of nursing and medicine within the health
care delivery context, with the objective being the improve-
ment of health care delivery services.)
William J. D'Elia, M.D., *Chairman* Spring Lake
Matthew E. Boylan, M.D. Avon-By-The-Sea
David Eckstein, M.D. Trenton
James A. Rogers, M.D. Paterson
John J. McGuire, M.D., *President*
(*ex-officio*) South Orange
Mr. Vincent A. Maressa, *Exec. Director* Trenton

Nursing Facilities, Advisory Committee on Skilled

(MSNJ representation requested by Assistant Com-
missioner for Health Facilities, New Jersey Department of
Health — 4/30/73. The Committee will revise standards for
licensure of skilled nursing facilities.)
David Eckstein, M.D. Trenton

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)
Howard Jacobson, M.D. Piscataway

**Ochompus (Office for Civilian Health and Medical
Program of the Uniformed Services)**

- (1) Fiscal Agent
(Designated upon request of MSP — 7/21/63)
Medical-Surgical Plan of New Jersey
- (2) Special Committee on
(Established by MSNJ — 9/9/56)
David Eckstein, M.D., *Chairman* Trenton
George L. Benz, M.D. Newark
I. Edward Ornaf, M.D. Cherry Hill

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child
Health — 12/20/64)
William J. Farley, M.D. Brielle

Pension Plan, Special Committee on

(Established by Board — 5/22/55 Duties outlined
in Article III of Pension Plan Agreement)
I. Edward Ornaf, M.D., *Chairman, Committee on*
Finance and Budget Cherry Hill
John J. McGuire, M.D., *Chairman, Special Committee*
on House Maintenance, Staff Policies, and Personnel
Relations South Orange
Rudolph C. Gering, M.D., *Treasurer* Trenton

Quockery, Committee on

(Established at the request of the AMA — 11/15/64)
James S. Todd, M.D. *Chairman* Ridgewood
Richard B. Berlin, M.D. Englewood
Charles B. Norton, M.D. Woodstown

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested
— 7/18/65)
Bernard M. Schnur, M.D. Trenton

Radiation Protection Commission, New Jersey

(Two consultants in nuclear medicine requested by the
Commission 11/66)
Frank R. Schell, M.D. Wayne
John J. Thompson, M.D. Caldwell

Regional Planning Council, Philadelphia Medical Library

(Appointment of representative requested by Library
Committee — 8/20/67)
Sherman Garrison, M.D. Bridgeton

Rehabilitation Services, Division of Vocational

(Liaison requested by MSNJ's Committee on
Rehabilitation — 5/65)
Jarvis M. Smith, M.D. Trenton

Resolutions, Committee on Annual Meeting

(Established, by Board of Trustees — 7/18/71 — to re-
view all resolutions in advance of the annual meeting)
James A. Rogers, M.D., *Chairman* Paterson
Matthew E. Boylan, M.D. Avon-By-The-Sea
William J. D'Elia, M.D. Spring Lake

Safety Council, New Jersey State

(Provided in Council bylaws)
John J. McGuire, M.D., *President* South Orange
Delma W. Caldwell, M.D., *President's*
Representative Linden

Selective Service System, New Jersey Chairman of Advisory Committee

(Nomination for appointment by National Advisory
Committee requested by committee — 11/19/61)
Charles L. Cuniff, M.D. Jersey City

Welfare Council, New Jersey

(Representative to plan meetings for annual conference on
social welfare requested by Council — 5/13/66)
John J. Bedrick, M.D. Bayonne

Widows and Orphans of Medical Men of New Jersey

(Liaison requested by Society — 5/17/59)
Joseph R. Jehl, M.D. Clifton

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Marihuana — A Political Drug

Recent agitation in the New Jersey Senate by Senator Menza for the liberalization of marihuana control (S-1461) is being duplicated in surrounding states, with support coming mainly from non-professionals. It is a rare physician who looks favorably on the liberalizing of any drug controls, for practitioners are the first to see the start of human tragedy from drug abuse.

In February 1975 the United Nations Commission on Narcotic Drugs adopted a resolution which said, "In view of the numerous findings of scientific research on cannabis (marihuana) *there can be no doubt as to the harmful nature of cannabis.*" The resolution called on more than 100 member nations to take appropriate measures against trade and traffic in all forms of cannabis. The ten sponsoring nations noted "with concern the recent increased availability in many parts of the world of new concentrated forms of cannabis" and suggested that any reduction of control by one country might increase the problem in other countries.

Based on observations and experience, responsible individuals have expressed concern about marihuana. In December of 1967 at Suffolk Superior Court in Boston, Chief Justice Tauro listened to twelve days of testimony by experts from all over the world and said, "It is my opinion, based on the evidence presented at this hearing, that marihuana is a harmful and dangerous drug."

Experience in this field compels one to oppose removal of a penalty for possession of any amount of marihuana for many reasons, including the following:

1. Removal of the penalty would, in effect, legalize possession of marihuana. This would certainly be construed by many as government sanction of marihuana use.
2. The sinister "dope-peddler" who lurks around schools attempting to recruit new customers exists only in the minds of fiction writers and those idealistic, impractical people who would like to have laws against "pushers" but not against "users," a term employed to describe persons who are in possession of marihuana. Unfortunately, the lines are not that clear cut and the problem is not that simple. *Drug habits are acquired from peers and friends*, not professional traf-

fickers. Legalized possession would increase the availability of the drug and could encourage a national problem that would make alcoholism insignificant by comparison.

3. As a matter of practical law enforcement, elimination of a possession penalty would force authorities to work with one hand tied. It is not always possible to obtain admissible, legal evidence of a sale, which usually requires a Federal agent to buy drugs from a peddler. Narcotic agents are among the most experienced undercover agents in law enforcement, but experienced traffickers will not sell to a stranger. The only alternative to an undercover purchase is surveillance which leads to an arrest for possession.

International Controls

Dr. I. C. Chopra, Director of Government Research at New Delhi, India, and his father have gained worldwide scientific acclaim for their marihuana research and for their numerous books and reports on the subject. Chopra states that his country has had two thousand years of experience with all forms of marihuana, which was legal and socially accepted throughout India until 1959. In that year the Indian government finally decided that the use of marihuana had caused such severe social and economic problems that it could no longer be tolerated and laws were passed which prohibit sale, importation, and possession. Chopra found it hard to believe that our young nation, with its limited experience, could even consider removing restrictions on this dangerous drug.

In 1924, the Union of South Africa proposed that all parties to the International Opium Convention of 1912 include marihuana in the list of controlled drugs. In 1925, the delegate from Egypt said his country was suffering great harm from the use of marihuana and asked that the Convention add marihuana to the list of controlled drugs.

Year after year, other nations outlawed marihuana and in 1961, the U. N. Commission on Narcotic Drugs adopted an International Treaty for control of dangerous drugs which requires all member nations to place marihuana in the same control category as morphine and other potent narcotics. This treaty, known as the Single Convention on Narcotic Drugs of 1961 has been adopted by more than 100 nations, including our own.

What Is Marihuana?

The word "marihuana" means many things to many people. In the United States it is generally used to refer to a preparation of ground leaves and flowering tops from a plant known botanically as *Cannabis*. *Cannabis* is a hemp plant which grows wild all over the world. Marihuana for smoking is prepared by picking the leaves and/or flowering tops of this plant, drying them and crushing this substance to the consistency of tobacco. The prepared or manicured marihuana preparation is then rolled into cigarettes or smoked in a pipe.

One important reason for all the controversy about the effect of smoking marihuana was our inability to determine the potency of a particular sample of marihuana until recently. Many research workers conducted experiments and arrived at totally different results for obvious reasons. One cannot study the effects of alcohol by using an ounce of vodka as a standard test dose and compare his results to those of another investigator who used an ounce of beer as his dose. Obviously, each would reach different conclusions regarding the effect of liquor on the human or animal. To be valid a scientific comparison would require equal amounts of the active ingredient, i.e., alcohol.

Most of the experimental research until recently has been unscientific and inconclusive because the active ingredient in marihuana had not been isolated and there was no standard for comparison. Today the active ingredient which causes intoxication is known to be tetrahydrocannabinol, or THC.

Potency of Marihuana and THC

The amount of THC in a marihuana preparation depends on where the plant was grown, when it was picked, what part of the plant the leaves came from, whether the plant was male or female and whether the preparation contains flowering tops from a female plant. The potency of any two marihuana cigarettes can be as different as the potency of an ounce of whiskey and an ounce of beer. If one considers other types of marihuana preparations, the difference in potency and effect is magnified tenfold. It is known also that the effect of any marihuana

preparation on a particular individual depends on many variable factors, including method of consumption, emotional stability, physical condition, state of mind, physical surroundings, expectations, mood, and previous experience.

It has been established that THC can and does cause psychotic reactions including paranoia and hallucinations. This can happen to every user who is exposed to large enough doses, and it does happen regularly enough to classify this drug as dangerous.

A study presented to the National Academy of Science and the National Research Council in 1967 described the effects of varying doses of THC consumed by smoking. Doses ranged from so-called "threshold doses" of 25 mcg/kg of body weight to 200 mcg/kg. This report concluded:

"It has long been known that marihuana and hashish can cause psychotic reactions, but usually such reactions were ascribed to individual idiosyncrasies rather than being usual or common reactions to the drug. The data in these experiments, however, definitely indicates that the psychotomimetic effects of THC are dependent on dosage and that sufficiently high doses can cause psychotic reactions in almost any individual.

"Psychotic reactions after smoking marihuana under the usual conditions in the United States appear to be rare, but the low incidence of such psychotic breaks may reflect nothing more than *the low THC content of most of the marihuana available in the United States.*"

Dr. Zigmond M. Lebensohn, Chief of Psychiatry at Sibley Memorial Hospital, Washington, D.C., said:

"I consider marihuana a serious problem for our 'alienated youth.' It is not harmless, as some users insist.

"Although people who use marihuana do not experience withdrawal symptoms when it is removed, they are tremendously drawn to it and many users go back to marihuana after they leave the hospital because they want to recapture the pleasurable feeling. This dependency is just as serious as a physical addiction.

"In my professional experience, I have seen a number of young people experience psychotic episodes precipitated by marihuana. Intense emotional experiences were sufficient to trip the balance in the direction of acute psychotic disorganization.

"This sometimes lasts for weeks and even months.

"In certain instances, the effects continue indefinitely and cause complete disruption of a life plan, tremendous expense to the smoker and his family and the end is often a totally unproductive human being.

"Some individuals have been able to use marihuana and get away with it, but these individuals have stable nervous systems. Most young people who smoke marihuana do not have stable central nervous systems and for this reason it is particularly dangerous for them."

Dr. Philip Solomon, Clinical Professor of Psychiatry at Harvard said,

"Some people have smoked marihuana for years and have experienced no damage whatever. For others, it has proved disastrous. Marihuana is not harmless. It may not be addictive, but it is habit-forming. In unstable personalities, marihuana can be the trigger that precipitates psychosis."

The proponents of liberalization of marihuana use the following defenses: (1) Marihuana is not a narcotic, (2) It is less harmful than tobacco or alcohol, and (3) It is not addictive.

All these statements are true but to have any meaning, we must define a few terms.

Marihuana is not a Narcotic — The word "narcotic" describes a drug in terms of its pharmacological action. Marihuana produces some of these actions, therefore several medical dictionaries describe it as a narcotic and many botanists agree with this term. Marihuana is classified as a narcotic under most state laws although some authorities now prefer to describe it as an hallucinogen, a new classification which only recently has become current. One must keep in mind there are hundreds of drugs which do not meet the medical definition of "narcotic" but are nevertheless highly dangerous.

As far as being less *harmful* than other drugs, the facts are not known. It may be true that alcohol and tobacco produce more tissue damage but the emotional and psychological harm from marihuana cannot be overlooked.

Marihuana is not addictive — Addiction to the

medical profession means at least two things: (1) the body undergoes a physiological change so that regular intake of the addicting drug must be maintained to avoid withdrawal symptoms; (2) a tolerance develops and the dose must be steadily increased to achieve the same effect. Neither of these factors is present in marihuana use, but, like tobacco, it may establish a strong psychological dependence. Heroin which is extremely addictive also creates an emotional dependence which adds to the physical addiction.

Habitual marihuana smokers may become increasingly preoccupied, through its abuse, to the point where they lose all interest in school, family, or job. They may become conditioned to escaping from reality and avoiding responsibility and some progress to other drugs to prolong the period of escape.

Halbach, Isbel, and Seevers in a *Bulletin of the World Health Organization*, entitled "Drug Dependence: Its Significance and Characteristics," state:

"For the individual, harm resulting from abuse of cannabis may include inertia, lethargy, self-neglect, feeling of increased capability with corresponding failure, and the precipitation of psychotic episodes.

"The harm to society derived from abuse of cannabis rests in economic consequences of the impairment of the individual's functions and his enhanced proneness to asocial and anti-social behavior."

It is hoped and urged that our legislators will not disregard the experience of one hundred other nations who, after two thousand years of experience with legal marihuana, found it necessary to outlaw that dangerous drug.

Martin H. Johnson
Executive Assistant

210th Annual Meeting — June 4-8, 1976

ANNOUNCEMENTS

Surgical Lectures — Rutgers Medical School

The Rutgers Medical School, CMDNJ, Department of Surgery, is sponsoring the following series of lectures, which have been approved for one credit-hour each in Category I of the AMA Physician's Recognition Award:

- October 7 *Nonspecific Colitides*
Rene Menguy, M.D., Professor of Surgery
University of Rochester School of Medicine
- November 4 *Surgery of Portal Hypertension*
William McDermott, M.D., Professor of
Surgery
Harvard Medical School
- December 2 *Use of Vasopressin in Upper Gastrointestinal
Hemorrhage*
Edward H. Storer, M.D., Professor of
Surgery
Yale University School of Medicine
- January 6 *Renovascular Hypertension*
William J. Fry, M.D., Professor of Surgery
University of Michigan Medical School

All lectures will be held at 5 p.m. in the main auditorium of Rutgers Medical School, University Heights, Piscataway. For further information please communicate with John H. Landor, M.D., Professor and Chief of the Division of General Surgery at the College.

Pediatric Arthritis Clinics

Under the auspices of the Greater Delaware Valley Regional Medical Program, demonstration clinics in pediatric arthritis will be conducted by the staff of the connective tissue clinic at the Children's Seashore House in Atlantic City from 9:45 to 11:45 a.m. on the dates listed:

- October 15 Juvenile Rheumatoid Arthritis
- December 17 Differential Diagnosis of Arthritis
- February 18 Treatment of Arthritis
- April 21 Arthritis in Children

Prior registration is required and admittance is limited to six physicians at each session. Two hours of AMA Category I accreditation will be awarded to those in attendance. Please call or write to B. H. Athreya, M.D., Children's Seashore House, 4111 Atlantic Avenue, Atlantic City 08401 — (609) 345-5191 — for information.

Seminar in Emergency Medicine

On November 12 and 13, 1975, at the Hyatt House, Cherry Hill, there will be a seminar in "Advances in Emergency Medicine," sponsored by the New Jersey Chapter of the American College of Emergency Physicians and the Emergency Department Nurses Association. Tuition is \$75 for member-physicians; \$85 for non-members. The fee for member-nurses is \$50 and for non-members, \$60. Emergency medicine paramedics and students are welcome at lesser fees. The closing date for reservations is October 31st. Physicians and nurses will meet first as a unit and later separate into groups for other programs. Registration opens at 8 a.m. and the session convenes at 9 o'clock. It is anticipated that 10 credits will be awarded in AMA Category I for those physicians in attendance. For additional information, please communicate with ACEP/EDNA, P.O. Box 308, Wharton, New Jersey 07885, attention of Mrs. Davis, or telephone (201) 366-1600, extension 308.

Graduate Course on Phenomenology and Treatment of Depression

On December 4 and 5, 1975, the Office of Continuing Education of Baylor College of Medicine is sponsoring a two-day course on phenomenology and the treatment of depression. All sessions will convene at the Shamrock Hilton Hotel in Houston. A faculty of basic scientists and clinicians with expertise in the investigation and treatment of depression will present current information on the nature and management of depressive disorders. There will be formal didactic presentations and an informal evening session when conferees and faculty will be able to exchange information. Tuition is \$150 and the program has been approved for 15½ hours of AMA Category I accreditation; it is acceptable for the same number of prescribed hours by the American Academy of Family Physicians. For additional information, please communicate with the Office of Continuing Education, Baylor College of Medicine, Texas Medical Center, Houston, Texas 77025.

Symposium on Congenital Heart Disease

The Deborah Heart and Lung Center, in cooperation with the continuing medical education department of Temple University Medical School, is sponsoring a symposium on congenital heart disease in infants and adults on December 5 and 6, 1975 at the Americana Hotel in New York City. Topics to be discussed include anatomical defects, heredity and congenital heart disease, complete transposition of the great vessels, myocardial function, hypertrophic obstructive cardiomyopathy, pulmonary hypertension, the symptomatic infant — surgery and post-operative care, non-invasive techniques, long-term results for surgery for cyanotic defects, and advances in surgical therapy. The program is acceptable for eleven hours of AMA Category I credit. Registration fee is \$75 (which includes luncheon each day); residents, fellows, interns, medical students, and nurses are welcome without charge. Please make your check payable to the Deborah Heart and Lung Center and forward it to Harry Goldberg, M.D., Deborah Symposium, Suite 1100, 110 East 59th Street, New York 10022. Further information about the sessions is available from Dr. Goldberg. A cocktail reception and dinner has been arranged for December 5 — \$22.50 per person. A number of guest rooms have been set aside for those attending the meeting; please make your reservation directly with the hotel before December 19, 1975.

Virgin Islands Clinical Conference

The Virgin Islands Medical Society (USA), in association with the faculty of the University of Pennsylvania School of Medicine, will hold a clinical conference in general practice, internal medicine, general surgery, and obstetrics/gynecology from January 29 to 31, 1976, in St. Thomas, V.I. Registration fee is \$125. The program is acceptable for fourteen credit hours in category I of the AMA Physician's Recognition Award. Lodging accommodations may be made directly with the headquarters hotel—Bluebeard's Castle. For additional information about the conference and concerning accommodations, please write *via* airmail to

Harold A. Hanno, M.D., Secretary U.S. Virgin Islands Medical Society, Box 1442, St. Thomas, Virgin Islands 00801.

Decibel and Diopter Society Meeting

The American Decibel and Diopter Society will hold its annual meeting in San Diego, California, March 14 to 21, 1976. Programs in eye, ear, nose, and throat have been arranged, as well as sessions on facial plastics. Papers for presentation at these meetings may be submitted to the Society (P.O. Box 463, Huntington, West Virginia 25701) to December 1, 1975. Approval has been given for AMA Category I accreditation for those in attendance. Registration fee is \$125 and should be sent to the Executive Director, Albert C. Esposito, M.D., Suite 100, Medical Center Building, 420 11th Street, Huntington, West Virginia. Accommodations for lodging must be made directly with the Hotel DelCoronada in San Diego.

Graduate Course in Emergency Medicine

A graduate seminar in emergency medicine will be held from March 19 to 22, 1976 at the Americana Hotel in Miami Beach, Florida. The program is sponsored by the Florida chapters of the American College of Emergency Physicians and the Emergency Department Nurses Association. Registration fee for physician members is \$125; for non-members, \$150; for nurse members the charge is \$75; for non-member nurses, \$100; the cost to interns and residents is \$40. For additional information, please communicate with the Registrar, 1976 Postgraduate Seminar, 1919 Beachway Road, Suite 5-C, Jacksonville, Florida 32207.

Course in Neurotology

March 22 through the 25, 1976, are the dates of a continuing education course in neurotology being sponsored by the Department of Otolaryngology of the School of Medicine of the University of Illinois. The four-day intensive course to be held at the Eye and Ear Infirmary of the University Hospital will offer a didactic and practical review of clinical neurotology. Included will be basic vestibular physiology and pathophysiology and testing methods applied in

functional examination of the vestibular organ; caloric testing procedures will be demonstrated using nystagmography. Patients will be tested by participating physicians and the history, symptoms, and test results will be discussed in informal conferences. Enrollment is limited to fifteen. Application forms are available from the Department of Otolaryngology, 1855 West Taylor Street, Chicago 60612.

Chemistry of Radiopharmaceuticals

The Department of Radiation Therapy and Nuclear Medicine of Hahnemann Medical College will sponsor a program in chemistry of radiopharmaceuticals on April 23 and 24, 1976, at the College hospital. The lectures have been designed to introduce chemists, physicians, technologists, and students to the radiopharmaceutical field. Twelve hours of instruction will be given in the historical development, design, synthesis, purification, quality control, pre-clinical and clinical evaluation, and kit commercialization of new candidate radiopharmaceuticals. The coverage of pharmacological methods, biochemical principles, and new agents under development will make the course of value

to established practitioners. AMA Category I accreditation is available for physicians. For information, please write to Carl G. Karsch, Administrator, Department of Radiation Therapy and Nuclear Medicine, Hahnemann Medical College Hospital, 230 North Broad Street, Philadelphia 19102.

Preceptorships for Practicing Physicians

The Medical College of Pennsylvania is offering a program of preceptorships for practicing physicians, in an effort to meet the needs of the individual physician in continuing medical education. It is designed to give both the general practitioner and the specialist the opportunity to update present skills and learn new techniques. Programs are available in anesthesiology, medicine, surgery, neurology, obstetrics/gynecology, pathology, pediatrics, psychiatry, and radiology. The date and time can be arranged to accommodate each physician. Approval has been given for AMA Category I credit. For additional information, please write to Gerald H. Escovitz, M.D., Associate Dean, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Oct.

13 Pediatric Happenings

20 12:30-1:30 p.m. — Overlook Hospital, Summit
27 (*Sponsored by Departments of Family Practice and pediatrics and AAFP*)

14 Psychiatric Case Conference

21 7:30 — Trenton Psychiatric Hospital
28 (*Sponsored by Trenton Psychiatric Hospital and Academy of Medicine*)

14 Chest X-Rays in the Ambulatory Patient

21 8-9 a.m. — Overlook Hospital, Summit

28 (*Sponsored by Department of Family Practice and AAFP*)

14 Family Practice Psychiatric Cases

28 12:30-1:30 p.m. — Overlook Hospital, Summit
(*Sponsored by Family Practice Residency Program and AAFP*)

14 Fluid and Electrolyte Imbalance

9 p.m. — West Hudson Hospital, Kearny
(*Sponsored by Nephrology Society of New Jersey, New Jersey RMP and Academy of Medicine*)

- 14 **Trauma with Shock-Treatment in Community Hospital**
8 p.m. — Ocean Point Nursing Home, Somers Point
(Sponsored by Shore Memorial Hospital and Academy of Medicine)
- 14 **Proper Use of Antibiotics**
9 p.m. — Bayonne Hospital
(Sponsored by Academy of Medicine)
- 15 **Medical Lecture Series**
22 9-11 a.m. — Riverview Hospital, Red Bank
29 (Sponsored by Riverview Hospital and Academy of Medicine)
- 15 **Suicide in Children and Adolescents**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Academy of Medicine)
- 15 **Electrocardiography and Coronary Artery Disease**
9 a.m.-4:30 p.m. — Sheraton Poste Inn, Cherry Hill
(Sponsored by Camden and Burlington County Heart Associations and Academy of Medicine)
- 15 **Management of Renal Insufficiency**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 15 **Didactic Psychiatry**
19 12:30-1:30 p.m. — Overlook Hospital, Summit
(Sponsored by Department of Family Practice, Psychiatry, and AAFP)
- 16 **Advances in Immunology**
4-6 p.m. — Institute for Medical Research, Camden
(Sponsored by Institute for Medical Research and AAFP)
- 16-17 **Gynecologic Laparoscopy**
Memorial General Hospital, Union
(Sponsored by New Jersey Fertility Foundation and Academy of Medicine)
- 17 **Weekly Family Practice Seminars**
24 12:30-1:30 p.m., Overlook Hospital, Summit
31 (Sponsored by Family Practice Residency Program AAFP)
- 17 **Anaerobic Infection**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 17 **Proper Use of Blood Gases**
12 noon — Freehold Area Hospital
(Sponsored by Academy of Medicine)
- 18 **Respiratory Therapy Symposium**
8:30 a.m. — St. Barnabas Hospital, Livingston
(Sponsored by New Jersey State Society of Anesthesiologists)
- 20 **Acute Renal Failure**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 20 **Current Treatment of Burns**
11:30 a.m. — Helene Fuld Hospital, Trenton
(Sponsored by Academy of Medicine)
- 21 **Current Chemotherapy of Malignant Disease**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by Academy of Medicine)
- 22 **Congestive Heart Failure**
2 p.m. — Cherry Hill Medical Center
(Sponsored by Academy of Medicine)
- 22 **Headache**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Academy of Medicine)
- 22 **Depression: Theoretical Considerations**
8:30-10:30 p.m., Mountainside Hospital, Montclair
(Sponsored by Academy of Psychoanalysis of New Jersey and Academy of Medicine)
- 22 **Connective Tissue Disease**
9 a.m.-3 p.m. — CMDNJ-Rutgers Medical School, Piscataway
(Sponsored by Arthritis Foundation, Rheumatism Association, and Academy of Medicine)
- 22 **Perinatal Seminars**
9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
(Sponsored by Newark Beth Israel Medical Center and Academy of Medicine)
- 22 **High Dose of Neuroleptic Treatment**
1 p.m. — VA Hospital, Lyons
(Sponsored by VA Hospital and Academy of Medicine)
- 22 **End-Stage Renal Failure**
2 p.m. — Christ Hospital, Jersey City
(Sponsored by Nephrology Society of New Jersey and Academy of Medicine)
- 22 **Review of Internal Medicine**
29 Sheraton Inn, Newark Airport, Elizabeth
(Sponsored by Academy of Medicine and CMDNJ — New Jersey Medical School)
- 23 **Thoracic Aortic Aneurysms**
12 noon — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
- 23 **Gastrointestinal Bleeding**
11 a.m. — John F. Kennedy Medical Center, Edison
(Sponsored by Academy of Medicine)
- 28 **Ultra-Recent Advances in Neurological Surgery**
7 p.m. — Englewood Men's Club
(Sponsored by Englewood Surgical Society and Academy of Medicine)
- 28 **Subcutaneous Mastectomy with Immediate Implants for Breast Disease**
8-9 p.m. — 113 Sagamore Road, Millburn
(Sponsored by Essex County Chapter, New Jersey Medical Women's Association and Academy of Medicine)
- 29 **Nephrology for the Practicing Physician**
8:45 a.m.-4:30 p.m., Helene Fuld Hospital, Trenton
(Sponsored by Helene Fuld Hospital and Academy of Medicine)
- 29 **Hodgkins' Disease and Lymphoma**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)

- 29 Acute Psychiatric Problems**
6:30 p.m. — Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)
- 31 Clinical Endocrinology**
12 noon — Montclair Community Hospital
(Sponsored by Academy of Medicine)
- Nov.**
— **Every Weekday Conferences**
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice Residency Program and AAFP)
- 4 Emergencies Seen in the Ambulatory Setting**
11 a.m.-12 noon — Overlook Hospital, Summit
(Sponsored by Departments of Family Practice and Community Medicine and AAFP)
- 4 Psychiatric Case Conferences**
11 7:30 a.m. — Trenton Psychiatric Hospital
18 (Sponsored by Trenton Psychiatric Hospital and
25 Academy of Medicine)
- 4 Survey of Allergy-Immunology**
11 11 a.m. — St. Elizabeth Hospital, Elizabeth
18 (Sponsored by Elizabeth Tri-Hospital Residency
25 Program and AAFP)
- 5 Medical Lecture Series**
12 9-11 a.m. — Riverview Hospital, Red Bank
19 (Sponsored by Riverview Hospital and
26 Academy of Medicine)
- 5 Review of Internal Medicine**
12 Sheraton Inn, Newark Airport, Elizabeth
26 (Sponsored by Academy of Medicine and CMDNJ —
New Jersey Medical School)
- 5 Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by Academy of Medicine and CMDNJ —
New Jersey Medical School)
- 5 Trends in Geriatric Psychiatry**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of
Medicine)
- 5 Advances in Understanding and Treating Asthma**
12 Dementias Encountered in Medical Practice
19 Psychiatric Disorders in Late Life
26 Stroke; Warning Signs and Prevention
9-11 a.m. — Middlesex General Hospital, New
Brunswick
(Sponsored by Middlesex General Hospital and
Academy of Medicine)
- 6 Advances in Immunology**
13 4-6 p.m. — Institute for Medical Research, Camden
20 (Sponsored by Institute for Medical Research and
AAFP)
- 12 Monthly Neuro-Radiology Meetings**
7:45 p.m.-10:15 p.m. — Morristown Memorial
Hospital
(Sponsored by Radiological Society of New Jersey and
Academy of Medicine)
- 12 Anesthesia Conferences**
8-9:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of
Pennsylvania School of Medicine)
- 12 Upper Endoscopy**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 13 Radiology Diagnosis**
6:30 p.m., Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)
- 17 Gallstones: A Medical Disease**
12 noon-1 p.m. — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and
Academy of Medicine of New Jersey)
- 19 New Jersey Regional Meeting**
American College of Surgeons
- 26 Diagnosis of Pelvic Disease-Office Gynecology**
6:30 p.m., Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)
- Dec.**
— **Every Weekday Conferences**
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice
Residency Program and AAFP)
- 2 Emergencies Seen in the Ambulatory Setting**
11 a.m.-12 noon — Overlook Hospital, Summit
(Sponsored by Departments of Family Practice and
Community Medicine and AAFP)
- 2 Psychiatric Case Conferences**
9 7:30 a.m. — Trenton Psychiatric Hospital
16 (Sponsored by Trenton Psychiatric Hospital
23 and Academy of Medicine)
30
- 2 Survey of Allergy-Immunology**
9 11 a.m. — St. Elizabeth Hospital, Elizabeth
16 (Sponsored by Elizabeth Tri-Hospital Residency
Program and AAFP)
- 3 Review of Internal Medicine**
10 Sheraton Inn, Newark Airport, Elizabeth
(Sponsored by Academy of Medicine and CMDNJ-
New Jersey Medical School)
- 3 Pathology as it Relates to Medical Conditions**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 3 Medical Lecture Series**
10 9-11 a.m. — Riverview Hospital, Red Bank
17 (Sponsored by Riverview Hospital and Academy of
Medicine)
- 3 Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School
and Academy of Medicine)
- 3 Psychiatric Aspects of Criminology**
17 Part I and Part II
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of
Medicine)

- 3 Can you Treat Depression?
 - 10 Application of Acupuncture in Medical Practice
 - 17 Recent Trends in Genetics
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
 - 4 Advances in Immunology
 - 11 4-6 p.m. — Institute for Medical Research, Camden
 - 18 (Sponsored by Institute for Medical Research and AAFP)
 - 10 Monthly Neuro-Radiology Meetings
7:45-10:15 p.m., Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)
 - 6 Program To Be Announced
Newark Beth Israel Hospital
(Sponsored by American College of Surgeons and Academy of Medicine)
 - 10 Anesthesia Conferences
8-9:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
 - 11 Management of Venereal Diseases
6:30 p.m. — Bridgeton Hospital, Bridgeton
(Sponsored by Bridgeton Hospital)
 - 15 Clinical Aspects of Colonic Cancer
12 noon-1 p.m., Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 17 Acute Abdominal Trauma and Peritoneal Lavage as Diagnostic Tool
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- Jan.
- Every Weekday Conferences
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice Residency Program and AAFP)
 - 6 Psychiatric Case Conferences
 - 13 7:30 p.m. — Trenton Psychiatric Hospital
 - 20 (Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 27
 - 7 Medical Lecture Series
 - 14 9-11 a.m. — Riverview Hospital, Red Bank
 - 21 (Sponsored by Riverview Hospital and Academy of Medicine)
 - 28
 - 7 Distinguished Lectures in Obstetrics and Gynecology
6 p.m. — Carriage Trade, East Orange
(Sponsored by Academy of Medicine and CMDNJ — New Jersey Medical School)
 - 7 Clinical Applications of Liver Physiology
 - 14 Respiratory Failure
 - 21 Recognition and Management of Heart Failure
 - 28 Fluid and Electrolyte Problems in Pediatric Practice
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
 - 14 Diagnosis and Monitoring of Shock
 - 21 Mitral Valve Disease
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 14 Anesthesia Conference
8-9:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
 - 14 Monthly Neuro-Radiology Meetings
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)
 - 15 Advances in Immunology
 - 22 4-6 p.m. — Institute for Medical Research, Camden
 - 29 (Sponsored by Institute for Medical Research and AAFP)
 - 28 Echocardiography in Assessment of Patient with Coronary Artery Disease
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- Feb.
- 3 Psychiatric Case Conferences
 - 10 7:30 a.m. — Trenton Psychiatric Hospital
 - 17 (Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 24
 - 4 Medical Lecture Series
 - 11 9-11 a.m. — Riverview Hospital, Red Bank
 - 18 (Sponsored by Riverview Hospital and Academy of Medicine)
 - 25
 - 4 Electrolyte Problems in the Aged
 - 11 Food Faddism and Hypervitaminosis
 - 18 Obesity-Fact and Fantasy
 - 25 Abnormal Uterine Bleeding
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
 - 4 Distinguished Lectures in Obstetrics and Gynecology
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 5 Advances in Immunology
 - 12 4-6 p.m. — Institute for Medical Research, Camden
 - 19 (Sponsored by Institute for Medical Research and AAFP)
 - 26
 - 11 Monthly Neuro-Radiology Meetings
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)
 - 11 Peritoneoscopy
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital, Jersey City)
 - 11 Anesthesia Conferences
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)

Mar.

- 3 Hormones in Office Gynecologic Practice
- 10 Risk Factors in Breast Cancer
- 17 Breast Problems Encountered in Office Practice
- 24 Epidemiology and Host Susceptibility Factors in Cancer
- 31 Office Dermatology
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

- 3 Psychiatric Case Conferences
- 10 7:30 a.m. — Trenton Psychiatric Hospital
- 17 (Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 24
- 31

- 3 Medical Lecture Series
- 10 9-11 a.m. — Riverview Hospital, Red Bank
- 17 (Sponsored by Riverview Hospital and Academy of Medicine)
- 24
- 31

- 3 Distinguished Lectures in Obstetrics and Gynecology
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)

- 4 Advances in Immunology
- 11 4-6 p.m. — Institute for Medical Research, Camden
- 18 (Sponsored by Institute for Medical Research and AAFP)
- 25

- 10 Monthly Neuro-Radiology Meetings
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

10 Anesthesia Conference

8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)

Apr.

- 6 Psychiatric Case Conferences
- 13 7:30 a.m. — Trenton Psychiatric Hospital
- 20 (Sponsored by Trenton Psychiatric Hospital)
- 27

- 7 Pathogenesis and Management of Uremia
- 14 Sensory Feedback in Neurological Disorders
- 21 Basic Principles of Behavior Therapy
- 28 Medical Aspects of the Psychiatric Consultation
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

- 7 Distinguished Lectures in Obstetrics and Gynecology
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)

- 14 Monthly Neuro-Radiology Meetings
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey)

- 14 Anesthesia Conferences
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)

- 17 Monitoring of the High Risk Patient
9 a.m. — St. Barnabas Hospital, Livingston
(Sponsored by St. Barnabas Hospital, Department of Surgery)

OBITUARIES

Dr. Robert H. Brundage

One of Essex County's senior members, Robert Howard Brundage, M.D., died on July 16, 1975, after a long illness. Dr. Brundage was graduated from Anderson Medical College in Glasgow, Scotland, in 1941 and practiced surgery in the East Orange area until illness forced his retirement. He had been on the staff at the East Orange General Hospital and at the Woodbridge State School. He was a member of the Academy of Medicine of New Jersey and had been a medical officer in the Army of the United States during World War II. Dr. Brundage was in the 69th year of his age.

Dr. Laurence A. Cahill

Laurence A. Cahill, M.D., one of Essex County's senior members, died at his home in South Orange on August 5, 1975. A graduate of the medical college of the University of Maryland in 1911, Dr. Cahill practiced industrial medicine and surgery in Newark until retirement in 1967. He operated the Cahill Clinic and had been associated with the St. James' Hospital in Newark. He had been a member of the Academy of Medicine of New Jersey. Dr. Cahill was 92 years old at the time of his death.

Dr. Jack J. Caleca

One of Sussex County's well-known general practitioners, Jack J. Caleca, M.D., died on August 4, 1975. A graduate of the University of

Marquette Medical School, class of 1939, Dr. Caleca practiced general medicine and surgery in Andover for many years, and was on the staff at the Newton Memorial Hospital. He was a member of the American Academy of Family Practice. Dr. Caleca was 62 years old at the time of his death.

Dr. John S. Denholm

Word has been received of the sudden death on July 27, 1975, of John S. Denholm, M.D., a member of our Union County component. Born in 1908 and a graduate of Duke University School of Medicine, class of 1935, Dr. Denholm practiced internal medicine in Westfield for many years. Prior to coming to New Jersey he had practiced briefly in Burlington, North Carolina. He was a Fellow of the American College of Physicians, and a member of the American and New Jersey Societies of Internal Medicine and of the American Diabetes Association. He was on the attending staff at Overlook Hospital in Summit. Dr. Denholm was a medical officer in the Army of the United States during World War II.

Dr. John Dragan, Jr.

One of New Brunswick's well-known internists, John Dragan, Jr., M.D., died on July 23, 1975. Born in 1923, Dr. Dragan was graduated from New York University School of Medicine in 1947 and pursued graduate work in internal medicine becoming board certified in his chosen field. He was a Fellow of the American College of Physicians and had staff appointments as senior attending in medicine at both Middlesex General and St. Peter's Hospitals.

Dr. Herbert Mallison

Herbert Mallison, M.D., a senior member of our Union County component, died on August 13, 1975, at the age of 79. A native of Germany, Dr. Mallison was graduated from the University of Breslau Medical College in 1921 and was a practicing neurosurgeon in that city until emigrating to the United States in 1939. He had graduate training in neurosurgery at the University of Breslau and in this country at Polyclinic and Mount Sinai Hospitals in New York, at

Jefferson Medical College, and at George Washington University Medical College. Dr. Mallison's offices were located in Plainfield and he was affiliated with the Muhlenberg Hospital and held staff appointments at several New York City hospitals.

Dr. S. Douglas Murray

The chief of surgery at the West Hudson Hospital in Kearny, S. Douglas Murray, M.D., died on August 18, 1975, at the hospital. A graduate of New York University Medical School in 1944, Dr. Murray practiced surgery in Kearny for many years. He was a diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons, and a member of the American Gastroenterological Society. In addition to his appointment at West Hudson Hospital, he was on the attending staff at Clara Maass Hospital in Belleville, St. Michael's Hospital in Newark, and the Hasbrouck Heights Hospital. Dr. Murray was assistant clinical professor of surgery at New Jersey Medical School, CMDNJ, Newark. He had served as medical officer in the United States Navy in both World War II and the Korean conflict. Dr. Murray was only 55 years old at the time of his death.

Dr. A. Downey Osborn

On August 4, 1975, A. Downey Osborn, M.D., a member of our Monmouth County component, died at his home in Belmar, where he had practiced for over forty years. Born in 1902 and graduated from the University of Edinburgh, Scotland, where he earned his medical degree in 1932, Dr. Osborn pursued graduate work in allergy at New York University Hospital, the specialty he practiced exclusively. He was on the staff at the Monmouth Medical Center in Long Branch and at the Jersey Shore Medical Center in Neptune. He had also been on the staff at the Allenwood Hospital during the 1950's. He was an athlete in his youth, having been on the varsity teams in lacross and football during undergraduate days at the University of Maryland. He was school physician for the town of Belmar and the Township of Neptune, and was a member of the New Jersey Society of Allergists and of the Allergy Foundation of America.

Dr. Edward C. Reifenstein, Jr.

One of Essex County's senior members, Edward C. Reifenstein, Jr., M.D., died on July 23, 1975, at Chilton Memorial Hospital after a long illness. Born in 1908 and graduated from Syracuse University Medical School in 1934, Dr. Reifenstein completed residencies in medicine and in psychiatry and spent most of his professional career in research and administrative medicine. He was employed in that capacity for Schering Corporation and for the Squibb Institute for Medical Research. He was also assistant clinical professor of medicine at New York Medical College. Dr. Reifenstein retired in 1973 and moved to Kinnelon in Morris County. He was a Fellow of the American College of Physicians, a member of the American Association for Advancement of Science, American Federation for Clinical Research, American Endocrine Society, American Society for Clinical Investigation, American Fertility Society, American Therapeutic Society, American Geriatric Society, and the Academy of Medicine of New Jersey.

Dr. Grace M. Robertson

Word has just been received of the death in Miami, Florida, on April 2, 1975, at the grand age of 90, of Grace M. Robertson, M.D. Dr. Robertson was graduated from Bellevue Medical School in 1923 and practiced general medicine in the Plainfield area until retirement in 1950. She had been on the staff of the Muhlenberg Hospital and was active in the American Women's Medical Association. Dr. Robertson moved permanently to Florida in 1970. She had maintained her membership in the Union County Medical Society.

Dr. Perla Satsch

Perla Satsch, M.D., a member of our Essex County component, died on August 8, 1975. Born in Russia in 1907 and educated in Germany and Austria, Dr. Satsch received her medical degree from the University of Leipzig in 1936. She came to the United States in 1941 and practiced in Boston and Cleveland before coming to New Jersey in 1960 to accept appointment as a staff physician at the Veterans Administration Hospital in Lyons. She was a member of the American Medical Women's Association.

Dr. Joseph C. Sweeney, Jr.

At the untimely age of 57, Joseph C. Sweeney, M.D., one of the Atlantic City Medical Center's anesthesiologists, died at the hospital on August 8, 1975. A 1941 graduate of Temple University's School of Medicine, Dr. Sweeney practiced anesthesiology in Brooklyn, New York, and was affiliated with four major hospitals there, before coming to Atlantic City in 1970. He was a member of the American Society of Anesthesiologists.

Dr. H. Austin Vogel, M.D.

H. Austin Vogel, M.D., formerly of Union, died on June 30, 1975, in Delmar, New York, after a prolonged illness. Born in 1893 and graduated from the Albany Medical College, class of 1915, Dr. Vogel was a roentgenologist and had been associated with the Elizabeth General and Rahway Memorial Hospitals for many years. He was a member of the Radiological Society of New Jersey and the Radiological Society of North America. Dr. Vogel was a medical officer in the American Expeditionary Forces during World War I.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

BOOK REVIEWS

Three Centuries of Microbiology. H.A. Lechevalier and M. Solotorovsky. New York, Dover, 1974. Pp. 536. (Softback — \$5)

This volume is an unabridged but corrected republication of a book originally published in 1965 by another company. It deals with one of the most exciting and important fields of human study. In three short centuries, man learned to cope rationally with the mysteries of the invisible and to understand its overwhelmingly large role in determining and controlling all life on earth. The authors have done a fine job of documenting that achievement. But, by stopping their historical accounts about two decades short of today, they have deprived the reader of a perspective fundamentally altered by that recent era of unprecedented creativity, originality, and productivity in microbiological science.

At its best, the recounting of history makes the flow of ideas and events come alive in relation to contemporary thought. Less valuable is a literary museum in which episodes are told as self-terminating anecdotes, leaving a chasm separating the then from the now.

The authors, both professors of microbiology at Rutgers, the State University of New Jersey, have succeeded in conveying a sense of the drama of discovery, by carefully selecting and documenting scientific milestones. The extensive quotations from many classical publications are of great value especially to professionals. Some are probably too technically detailed to convey much meaning to the lay reader. On the other hand, the brief biographical sketches of key personalities are inadequate to furnish more than trivial, sometimes excessively charitable, sometimes gossipy or condescending glimpses at highly complex individuals and their times. These notes and the excessive technical details tend to disrupt continuity. They might have been shortened or omitted in favor of carrying historical developments closer to the present.

These criticisms do not detract from the value of this book to any student or practitioner of microbiology and to anyone interested in the history of scientific thought generally. It is the only one of its kind and clearly represents prodigious labor of love by the authors.

R. Walter Schlesinger, M.D.

The Key to the Sciences of Man. D. G. Garan, Ph.D. New York, Philosophical Library, 1975. Pp. 561. (\$10)

To review Dr. Garan's profound book in one typewritten page is a difficult task, indeed. It introduces a new concept of "the Law of Relative Causation" of all human behavior and social reactions. The author believes that relativity works by a logic that is exactly contrary to the logic of the present exact sciences especially in explaining deviations of personal behavior such as in psychiatric illnesses. But he feels also that experiences like pleasure and satisfaction make "causally no sense unless the relative causation is understood." He proposes that every value, as satisfaction, release, or restoration of sameness, requires equal need, restriction, or disturbance. But he goes a step further and postulates that modern man is attaining improvements in

prodigiously rich, ingenious ways. The result is the progressively deepening impoverishment — much as in drug use — of all his potentials from organic functions to social reactions. He thinks that three-fourths of the people best-cared for now die from functional diseases, that have remained admitted mysteries causally. Freedom from need, anxiety or stress is the highest value and the easiest thing to enjoy. The unconscious is often blamed for unwanted negative reactions, which actually are the automatic opposite effects of our equally ingenious overenjoyments. Under present concepts, i.e., the like-from-like causal logic, positive reactions, such as satisfactions and capacities, are believed to derive from positive causal backgrounds. This is supposed to lead to a virtual modern alchemy, of trying to create our most precious human potentials by increasing the easy satisfactions or enjoyments. We can have unlimited capacities, as releases, but we have to "pay" for them with equal restrictions, which are viewed as the greatest evils in the modern scientific thought.

The age-long restrictive cultural and moral wisdoms are now rejected. Since the real sources of all values are their never recognized value opposites, the science and theory miss the real, most important, causal negative side of the world of mind, behavior, and knowledge of reality.

The book is arranged in ten chapters applying "the Law of Relative Causation" to different spheres of science: psychology, psychiatry, functional diseases such as heart disease and hypertension, education and sexual maladjustments, social sciences, theory of life and genetics, philosophy, and finally religion.

Each chapter has a concise summary at its end as well as an outline of issues at its beginning. The foreword, and the final conclusions at the end of the book, state its principle ideas. Dr. Garan's book presents a completely new approach to causal relationships in psychiatry and as such it makes most interesting reading for the physician. If the reader approaches the book without prejudice and is willing to accept new ideas the book offers some new and original thoughts and represents a provocative study.

Werner Steinberg, M.D.

Textbook for Midwives, 8th edition. M. F. Myles. New York, Churchill Livingstone, 1975. Pp. 796. Illustrated. (\$15)

Although Sister Myles' excellent textbook is intended primarily for midwives, it would be of considerable value to all obstetrical nurses who function to a certain extent in the capacity of midwives. The scope of this book is sufficiently broad that it would be useful to foreign medical graduates preparing for state board examinations. Undoubtedly there is a universal need for such a textbook for midwives who still deliver the majority of babies in this world today, and Sister Myles has succeeded admirably in this task. The book is well-printed and well-illustrated and its paper-back form represents a relatively easily portable convenience that could and should be kept available in every delivery suite.

There are four or five minor errors possibly denoting reasonable differences of opinion, but actually connoting something more significant — namely, a disproportionate emphasis upon the ultra-scientific or technical academic approach with decreased emphasis upon the practical, common sense, intuitive approach. Amniocentesis at fourteen weeks for determination of genetic abnormality implies a fast and easy solution to a dilemma. No! An alert midwife could and should recognize and recommend simple, practical measures to manage uterine displacement and hyperemesis

gravidarum. A bleeding antepartum patient might resolve her difficulty quickly and easily by expelling a fetus if an over-zealous midwife does not wrap her hips and thighs too tightly. Amniotomy might be performed on a bleeding antepartum patient in her more readily available bed than in an operating theatre. Each of these points is minor compared to the tremendous amount of information presented in nearly 800 pages by Sister Myles, but her readers are also seeking solid common sense, practical advice as well as ponderous, voluminous facts.

Jerome Abrams, M.D.

How To Beat Fatigue. Lindo Pembroke. Garden City, New York, Doubleday, 1975. Pp. 223. (\$6.95)

"Doctor, why am I so tired and yet I don't do a thing all day!"

How often have we heard this preamble to a list of complaints offered by so many of our patients, who look so well developed, well nourished and in no acute pain or distress? How often have we sat back after listening to the catharsis of symptoms and wondered for ourselves where to begin to apply our scientific knowledge and ability to help the tired patient. What do they mean when they say they are tired?

Linda Pembroke has composed and written a fascinating book on this subject. She has gone to the experts for the best advice available and is ready to offer practical recommendations to the reader.

Her thesis is divided into (a) physical fatigue, and (b) emotional fatigue. She then lists and discusses the many factors that produce the symptoms of tiredness in each group, usually the most common types. Each chapter has a short bibliography of references.

This is a nice little book and it covers the subject without overwhelming distractions of charts, graphs, and figures. In her last chapter, she applies positive thinking approach with a list of "what-to-do-in-case-of —."

I would recommend the book to the primary care physician for personal use, who feels "bushed" at the end of the day after seeing so many tired patients. What he learns for himself will also help his patients.

Harry M. Poppick, M.D.

Welfare Medicine in America: A Case Study of Medicaid. Robert Stevens and Rosemary Stevens. New York, Free Press, 1974. Pp. 386 (\$13.95)

An admirable volume, this is a serious attempt by a husband and wife team, teachers of law and public health, to assess the history of Medicaid and to make objective judgments and recommendations for the future based upon lessons of the immediate past and the present application of the program. The impact of Title XIX of the Social Security Act (Medicaid), enacted in 1965, upon medicine cannot be minimized or underestimated. Its accomplishments and failures, its logic and irrationalities, its administration and mistakes, its benefits and hardships, its divergent fundamental philosophies in respect to its character: a welfare program or a medical care program, are all covered in great, almost excruciating, detail with abundant supporting evidence.

Suggested for the library of the study of governmental health programs; highly recommended for state and national medical society officers and committee members who are in-

involved in national health programs; very strongly recommended for authors of resolutions and extemporaneous speakers and most hopefully to be read by legislators and their staffs. Quoting another, "an heroic task of collecting and organizing a segment of contemporary (medical) history that is still in process." A job well done!

James E. D. Gardam, M.D.

Davidson's Principles and Practice of Medicine, 11th edition. John MacLeod, Editor. New York, Churchill Livingstone, 1975. Pp. 1035. (\$16)

Here is a textbook for students and doctors edited by Dr. John MacLeod, an eminent physician and author of Edinburgh, and compiled by numerous contributing physicians, each an authority in his field of medicine.

No attempt is made to include all diseases, but to devote most of the available space to illnesses commonly found in clinical practice. Other materials included are based principally on educational value. Although diseases such as typhoid fever and rabies are rarities in Britain and tuberculosis has markedly decreased, these conditions have been included. Combined with a separate supplement dealing with tropical diseases, this book has been well received in Asia, Africa, and other European countries.

The text is well written, brief, factual but not encyclopedic in extent. Diseases are analyzed by cause and the systems involved. In addition, chapters cover poisoning, psychiatry, and industrial practices. Each chapter has its lists of references.

If a book choice has to be made for the library in a hospital or medical school of this volume versus its American counterpart, this reviewer would prefer our published texts, because of their superiority of content and presentation.

Harry M. Poppick, M.D.

Interpretation of Diagnostic Tests: A Handbook Synopsis of Laboratory Medicine, Second Edition. Jacques Wolloch, M.D. Boston, Little, Brown, 1974. Pp. 529. Illustrated (\$7.95)

This is a firmly bound paperback, clearly printed on quality paper. It is comprised of four major parts on subject headings as follows: Part I, Normal Values; Part II, Specific Laboratory Examinations; Part III, Diseases of Organ Systems; and Part IV, Effects of Drugs on Test Values. The table of contents itself is 33 pages and the index extends from page 471 through 529. This is a very complete book on usage and significance of laboratory values. It tells nothing of methodology for its intent is not to explain the technique of laboratory tests but rather their significance. To quote Dr. Wallach in his introduction, "This book is written to improve laboratory utilization by making it simpler for the physician to select the most useful laboratory tests for his clinical problems." It admirably fulfills this intent and does even more.

I recommend it for the carrying case of all physicians who order and interpret laboratory tests on patients. I find it so useful that I have two, one on my desk in the hospital and one on my telephone desk at home. I find it also intellectual fun just for browsing. It should be useful also for medical students to help them through the maze of modern laboratory medicine.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous

occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 to 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



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Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

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Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Important Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, periph-

eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 G sulfisoxazole and 50 mg phenazopyridine HCl —bottles of 100 and 500.

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OF THE MEDICAL SOCIETY OF NEW JERSEY

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November 1975

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Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease, systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpre-

dictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dys-

pepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

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Serum K⁺ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Warning

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly paired. Enteric-coated potassium salts may cause small bowel stenosis with or without obstruction. Hyperkalemia (>5.4 mEq/L) has

been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and

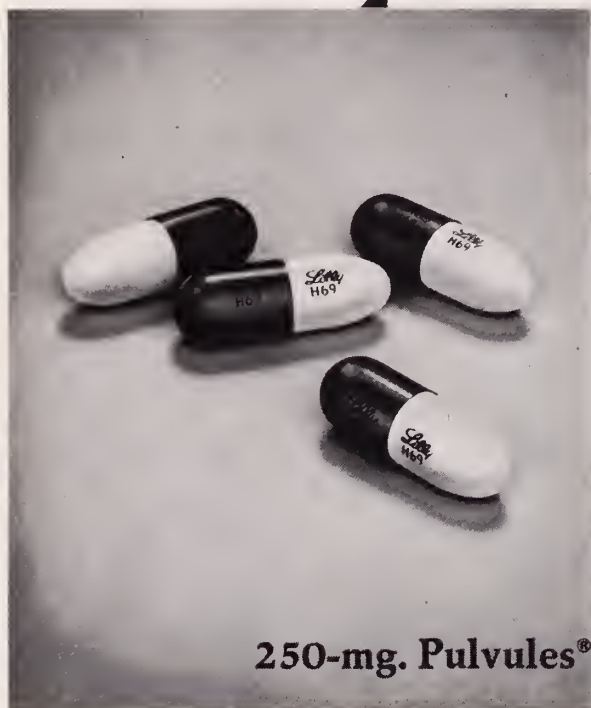
BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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EDITORIALS

Informed Consent

The doctrine of "informed consent" is based on the concept that the patient has the right to know the facts affecting medical or surgical risks his physician advises him to undertake. This does not require every physician to go into every remote possibility with every patient. The law recognizes the validity of professional judgment in this regard. There are, however, certain guidelines which serve to indicate what disclosures must be made and under what circumstances. The following points are salient:

Clearly, the physician owes his patient the duty to refrain from misrepresentation of risks involved. Likewise, he may not minimize dangers which are to be anticipated.

Instances of deliberate misrepresentation are, as one would assume, extremely rare. Most contested events involve the failure of the practitioner to explain what the consequences might be. The obligation to warn depends upon the circumstances in each case as well as the accepted practice of the medical profession in a given locality. The physician, generally speaking, is not usually required to inform the patient of risks which other reasonable physicians in his area would not think necessary to disclose. Patently, there is an increased duty to disclose when the risks accompanying a course of therapy or a procedure are unusually serious, if anything goes wrong. This rule is applicable not only in surgical procedures, but also in the administration of drugs with known severe side effects, especially when prescribed for a less than critical illness.

New and unusual therapies, procedures, and medications establish an even higher standard of disclosure. The more unique the therapy, the greater the obligation to explain.

When an alternate course of therapy exists, the patient must be so advised. This does not mean that the physician must always recommend

more conservative or less dramatic approaches, but he is obligated to inform the patient of their existence. The patient has the right to determine the course of action.

The test of understanding by the patient is, of course, purely subjective. The patient must understand what is being explained and the physician must pursue this avenue until he knows the patient and/or his family understand clearly.

In the final analysis, the physician as a reasonable, enlightened, and concerned professional is expected to discuss material factors with the patient concerning the projected course of therapy and its professionally anticipated complications.

Vincent A. Maressa

Diabetes Month

Diabetes Detection Week has been changed to Diabetes Month — a timely recognition of the increased importance of this disorder. In 1974, the 93rd Congress passed a National Diabetes Mellitus Research and Education Act (P.L. 93-354) which provides funds for the establishment of a National Diabetes Commission (NDC). In its wisdom, the Congress decided that it is high time to evaluate thoroughly the problem of diabetes mellitus, which now affects an estimated 10 million people in this country.

The NDC, with a number of committees and subcommittees, has held conferences and workshops and public hearings in major cities from coast to coast. They have listened to countless hours of testimony by citizens from all levels, representing themselves or local, state, and national organizations with an interest in diabetes. They have consulted with world and national experts in the genetics of diabetes, the riddle of human beta cell transplantation, the potential of the glucose sensor — artificial pancreas system, new modes of therapy, current understanding of diabetic neuropathy, special approaches to the juvenile diabetic, the socioeconomic impact of diabetes, and other

hypothetical and pragmatic aspects of this ominously prevalent metabolic disorder.

The pounds and pounds of written material on the subject will be sifted, reduced, and organized into a report for the U. S. Congress due December 31, 1975. What will come of it all? We must hope that funds will be forthcoming to permit implementation of the recommendations of the Commission.

In the meantime, look for diabetes during Diabetes Month; educate your patients and their families.

A.K.

Adopted Children As Adolescents

Most families accept and raise adopted children with minimal difficulty. Despite conflicting and often confusing advice, these parents intuitively do the correct things for their own family and their adopted children. The child is perceived as their child and he feels like their child.

Some parents have difficulty adjusting to and accepting an adopted child. In many cases the issues relate to one or both parents. If one parent wanted to adopt a child and the other did not or was ambivalent but went along with the adoption anyway, this ambivalence might interfere with the relationship with the child. In some families the adopted child is a reminder to the parent who was not fertile of his or her inadequacy, thus an ambivalent or negative relationship develops. The adopted child might be a reminder to one parent of the other parent's physical inadequacy and this again, may prevent a positive relationship. Parental ambivalence may show up in the style of child rearing. Under stress, this might surface as a parent "threatens" to get rid of the child by sending him or her back to "the agency."

On some occasions the extended family has difficulty accepting the adopted child. Grandparents may favor "natural grandchildren" and

have difficulty establishing as close a relationship with their adopted grandchild, who may sense the difference.

Each adopted child arrives in the new family with some pre-established issues. The quality of maternal health and care may have influenced development. Hereditary factors relating to organic illnesses, psychotic illnesses, intellectual potential, and academic disabilities are usually not known, but would influence the development of the child if present. Even when there is no clinical evidence of such problems, some parents, when under stress, think of the possibility. The child's behavior is blamed on his inherited characteristics and he is seen as a "bad seed."

The adopted child may have difficulty with the several developmental tasks of adolescence. An early mission of adolescence is to move from a dependent to an independent level of functioning. To prove his independence, the adolescent sometimes challenges the parent's authority and values. During this time, it is not unusual for an adolescent to fantasize "good parents" vs. "bad parents." Adopted children often begin to fantasize about their natural parents, feeling that they "would not do things" like their adopted parents, but would be good parents. Sometimes they romanticize the natural parents and wish to seek them out. They ask questions and express a longing for them. Most adopted adolescents go through this stage with minimal difficulty, however, if some of the relationship difficulties discussed earlier developed during childhood, there may be serious difficulty. They may develop behavioral problems or run away in hopes of finding their real parents. They may verbalize the feeling that the adoptive parents don't love them as much or are not as good as the natural parents.

The second task of adolescence, which is often not begun until the adolescent begins to feel somewhat independent, deals with the search for his own identity. Unlike the young child who resolves his identity by deciding to become "just like" the parent of the same sex, the adolescent seeks a broader goal. He selects characteristics of parents, religious leaders, scout leaders, neighbors, and relatives. He then blends all of

these characteristics with his developing personality, gradually evolving into a unique person or identity. During this time, adopted children might begin to muse about their biological origins and their ethnic, cultural, or religious backgrounds. Most adolescents also handle these concerns with minimal difficulty, but some do not. If there has been overt or subtle stress in the family, the adolescent may act out his concerns by rebellion or flight from home to seek the biologic parents.

The last task of adolescence, which begins in mid-adolescence and continues through young adulthood, is the establishment of intimacy. Intimacy refers to the ability to relate to adults as adults rather than as children. They shift from a dependent relationship with adults to an independent or intra-dependent relationship. They begin dating, develop courtships and ultimately marry. Under these circumstances, the adopted adolescent struggling with his biological origins, may become curious about his parents' origin and about his background. Adolescents who have grown up in a comfortable environment usually have no difficulty resolving these concerns. If there has been stress in the family or if the adolescent has not yet worked out the issues of being adopted, he may show behavioral problems.

All of these stresses of adolescence are greatly compounded when the race of the adopted child is different from the parents' race. Because of the decreased availability of white infants for adoption, more white couples are adopting black, oriental, or mixed-race infants. All of the potential problems are faced with greater difficulty by these adolescents. They become most critical around the concerns with identity and with intimacy. They struggle with their identity for they do not fit into any peer group. The black child raised by white parents may find, in adolescence, that he is not totally accepted by either the black community or by the white community. Dating, becomes a problem, while the possibility of having children of his own raises all the issues of biologic origin.

Most adopted children grow up in families with parents who were very enthusiastic about adopt-

ing, so the children feel accepted and loved and have little difficulty going through the developmental stages of childhood and adolescence. Adopted children, who have difficulty during adolescence, often come from families where the issues of adoption were never fully accepted or handled. Inherited characteristics may explain some of the problems, but I suspect that family dysfunction is the basis of the acting out behavior in many of the cases.

Goodman and Mango-Nora studied some adopted children who had difficulty during adolescence and explore some of the issues relating to the acting-out behavior. (See article, page 922, this issue.) Their findings support the concept that the behavior related either to the adolescent's difficulty resolving developmental tasks and/or to family dysfunction.

Larry B. Silver, M.D.

Life Month

November is the eighteenth "Life Month" for our original nationwide life insurance program. Three million dollars have been paid to beneficiaries under this plan. Each unit of insurance provides \$10,000 of death protection with double indemnity in case of accidental death, as well as a guaranteed conversion provision and a waiver or premium provision without extra charge.

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A special "Life Month" mailing is being sent this month by our administrator, who will be happy to provide help and information as to the best uses of the total program for your circumstances. Look for your application in the mail.

David Blanksteen

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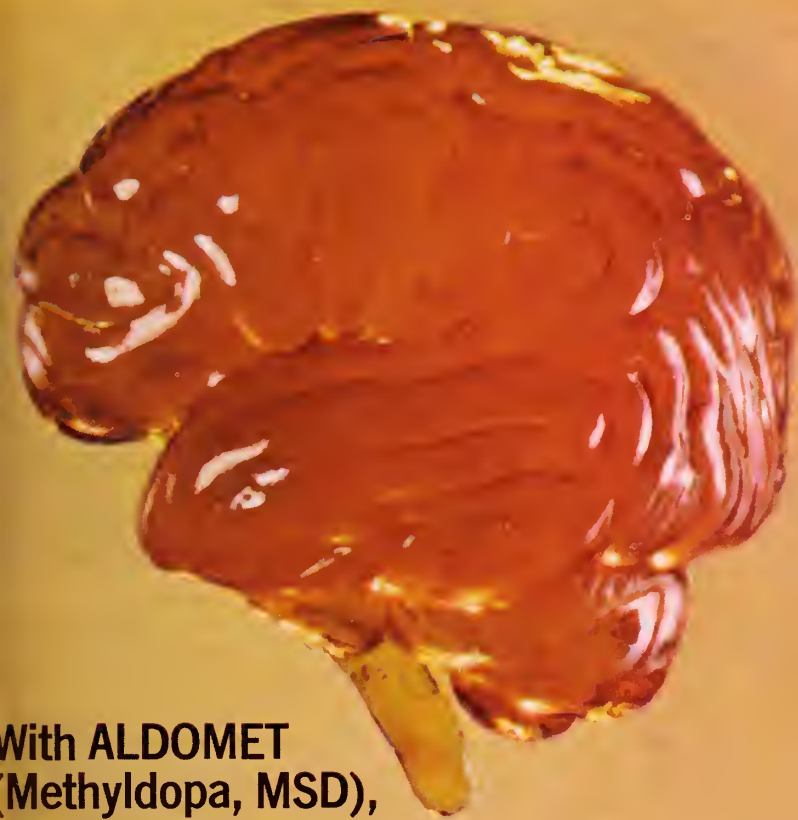
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For a brief summary of prescribing information, please see following page.

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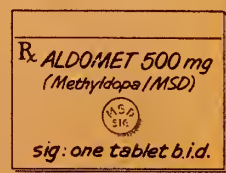
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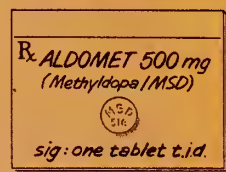
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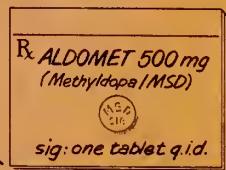
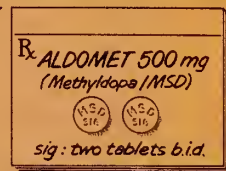
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dose =



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dose =



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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movement occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patient on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decrease mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, so-called "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited 500 mg daily when given with antihypertensive other than thiazides. Tolerance may occur, usually between second and third month of therapy. Increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Side effects in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000. Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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MSD MERCK SHARP & DOHME

ORIGINAL ARTICLES

It has become apparent that immunology plays a very important part in our fight against cancer. This article presents current concepts of immunologic defense against tumor development, and describes the present status of immunodiagnosis and immunotherapy of tumors.

Tumor Immunology for Clinicians

**T.S. Li, M.D., J.C. Sama, M.D.,
H. Caterini, M.D., M.A. Pelosi, M.D.,
and H.A. Kaminetzky, M.D.
Newark***

Immunologic Defense against Tumor Development

In the early 1950s, Burnet theorized that the body manages to cope with the enormous range of microorganism invaders through its ability to recognize "self" and to reject everything that is "non-self." A few years later, Burnet and Thomas postulated that the immune system also has a duty to police abnormal cell growth and to prevent the survival and replication of "outlaw" cells in addition to protecting the body from invading microorganisms. The body, in which cells are continually replicating, produces innumerable genetically different and potentially cancerous mutant cells each day. Ordinarily, the immune system recognizes these neoplastic mutants as "foreign," because they are genetically different, and destroys them before they begin dividing and reproducing. When the defense mechanism is weakened and fails to do away with the outlaw cells which are not under the same genetic restraints as normal cells, they "run wild" and become malignancies.

This surveillance against development of tumors mainly belongs to an immunologic mechanism called "allogeneic inhibition," which differs from the classical immune mechanism in that no previous exposures to foreign antigens are necessary. Immunologically competent lymphocytes continually patrol the body seeking out cells that have undergone mutative changes which have rendered them unrecognizable as "self." This surveillance mechanism helps to protect the integrity of the body.

During a lifetime, each individual is exposed to many different external invaders. Fortunately, the body also has a tremendous stock of immunologically inducible cells against those invaders. It has been calculated that man has approximately 10,000 to 100,000 basic kinds of inducible cells, each of which can respond to a number of closely related antigens. In a hypothetical example man may have one inducible cell for treponemas, one for pasteurellae, and one for salmonella bacilli. If he is invaded by treponema pallidum, that inducible cell against treponemas will be influenced to produce antibodies against it. If he never comes in contact with pasteurellae, that inducible cell against pasteurellae will not be used. Each person has a different spectrum of inducible cells. If a person is genetically programmed to have a poorly inducible cell against vibrio comma, and he unfortunately is invaded by the vibrio, he is destined to die of cholera. In a parallel speculation, one who may die of cancer may be already genetically programmed in his spectrum of immune mechanism against cancer.

Another hypothesis suggests that an individual may also have a time-programming mechanism for his life span. For example, a woman is programmed for the menarche and the menopause, and when and to what extent her immune system will deteriorate; environmental factors, however, can also influence the inherited mechanism. The immune system tends to deteriorate with age, so this may explain why more malignancies appear in the aged. A man who is time-programmed not to have much deterioration

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in his immune system in old age, need not fear cancer.

One of the most convincing evidences that the growth of cancer can be affected by immune resistance came from the rapid growth of incidental tumors transplanted with a renal homograft in patients who were under immunosuppressive therapy. Wilson, *et al.*¹ reported the transplant of an apparently normal cadaver kidney from a patient who died with a bronchogenic carcinoma. Eighteen months later, a tumor found to be surrounding the transplanted kidney in the recipient proved to be a carcinoma morphologically identical with the primary lesion of the donor. The patient's immunosuppressive treatment was stopped, and the grafted kidney was rejected and removed. An exploratory laparotomy several months later revealed no evidence of tumor, so another kidney was grafted into the patient. Immunosuppressive therapy was resumed and the patient remained free of tumor.

Should you cut a finger during surgery on a cancer patient, you need not worry about getting cancer implants as long as you have a healthy immune system; the implanted cancer cells will be killed promptly by your lymphocytes.

Other evidences that show a relationship between immune resistance and cancer growth are as follows:

1. Convincingly documented cases of spontaneous regression of cancer, and the more common instances of patients who survive for long periods in apparent biological equilibrium with their cancers, suggest a natural immunologic control over cancer.²
2. An increased incidence of malignant disease is observed in patients with congenital immunologic deficiency diseases such as ataxia telangiectasia.³
3. Cancer patients with a general depression in their immune reactivity have more rapidly growing neoplasms and a poor prognosis following surgical therapy.⁴

Besides spontaneous mutation, any cause which

may induce cellular mutation such as viruses, chemicals, and radiations can lead to oncogenesis. Once such a tumor occurs, it develops tumor-specific antigens which can be detected by immunocompetent cells of the body as "non-self." The immune system will then be stimulated to combat the tumor. It is believed that it is not the humoral but the cell-mediated immune system which is most effective in killing the cancer cells. If the cell-mediated immune system is victorious over latent stage cancer, the host will never know he has had an aborted cancer. If for some reason, the developing cancer overcomes the immune system, a clinical cancer develops. Clinical cancer develops due to one or more of the following escape mechanisms:⁵

1. The tumor cells proliferate so rapidly that they outpace the immune capacity of the host,
2. Eventually the host is in a state of immunosuppression or immunodeficiency,
3. The tumor cells do not produce or disclose specific antigens, and thus avoid the body's recognition mechanism,
4. The tumor-specific antigens are initially presented to the host in small but gradually increasing quantity which is unfavorable to the development of active cellular immunity,
5. The mechanism of tumor enhancement through humoral antibodies (as discussed below).

Humoral antibodies are effective agents in attacking antigenic substances and unicellular invaders. The cell-mediated immune system, chiefly the small lymphocytes, is designed to attack some special unicellular invaders such as tuberculous bacilli, and multicellular structures including cancers and transplanted organs. In an attempt to determine if anti-tumor humoral antibody can destroy tumor cells, early tumor immunologists immunized mice with killed tumor cells to produce anti-tumor humoral antibody. Tumor homografts which were normally rejected in eight to ten days after transplantation were not rejected as expected but seemed to be enhanced by the humoral antibody. This

phenomenon was named "immunologic enhancement" and the antibody was called "enhancing antibody" or "blocking antibody." One possible explanation of this phenomenon relates to the presence of antigenic sites on the surface of tumor cells. If the antigenic sites are attacked by lymphocytes the tumor cell will die. If the antigenic sites are occupied by the "enhancing antibodies," however, the attack is not lethal and, in fact, the tumor cell is actually protected from attack by the lymphocytes. Thus, growth of the tumor cell is enhanced.

The hypothesis of Hellström and Hellström,⁶ states that actively growing tumors can release quantities of tumor antigens to combine with the humoral antibodies to form specific antigen-antibody complexes. If the quantity of the antigen is much larger than that of the antibody, there will be some antigenic sites left unoccupied on the antigen-antibody complexes, and these antigenic sites of the complexes can block the cytotoxic activity of the sensitized lymphocytes leading to the enhancement of tumor growth. On the other hand, regressing tumors do not release too much tumor antigen. If the quantity of the humoral antibody is much greater than that of the released antigen, there will be no antigenic sites left unoccupied on the antigen-antibody complexes, and hence no blocking against the sensitized lymphocytes. In such circumstances, the humoral antibody is called "unblocking antibody" since it does not cause tumor enhancement.

The increasing incidence of cancers may be attributed to human longevity or to increased exposure to cancer-causing agents, such as chemicals and radiation. Other speculations concerning tumor development deserve consideration. Gold and Freedman⁷ discovered an antigen in human colonic carcinoma that was absent from normal human colon but present in fetal gut epithelium, they named it carcinoembryonic antigen. Later, it was found to occur with many, but not all, malignant tumors; the antigen was particularly common in malignancy of the gastrointestinal tract, breast, and bronchus. Stonehill and Bendich⁸ found that the reappearance and persistence of embryonal antigens are universal phenomena in all kinds of malignant cells, at least in the mouse. They con-

sider oncogenesis a "retrogenetic expression" in which the tumor has acquired the high proliferative activity of the embryo without its shut-off mechanisms.

If flocks of chickens were jumbled up by transferring members repeatedly from one flock to another, social positions were made uncertain and the birds stressed, they developed a much higher than usual incidence of a virus-induced tumor. Life under high social stresses might make people more susceptible to cancers, because increased stress-induced cortisol secretion may cause immunosuppression, which favors oncogenesis. Australian aborigines, among whom malnutrition is common, have a high prevalence of recurrent bacterial infections but a low rate of viral infection and cancer. Protein deficiency of a certain level, while depressing humoral immunity, might actually enhance cellular immunity and resistance to tumors.

Concerning the oncogenesis of cervical cancer, an etiologic relationship between the cancer and the type 2 herpes virus still remains highly enigmatic,⁹ although a recent finding that a common antigenicity exists among cervical cancers is consistent with the proposed viral etiology. Cervical cancer seems to be associated with coitus and behaves somewhat like a venereal disease. Nuns rarely develop the disease, while the age of onset of the cancer is younger in more sexually promiscuous groups. In a study which compared 900 women with genital herpes to 600 women without the infection, the incidence of cervical cancer was eight times higher in the first group than the second. However, the cause and effect relationship is yet to be proved.

Immunodiagnosis of Tumor

Radioimmunoassay for Carcinoembryonic Antigen (CEA) in Serum — A radioimmunoassay which was developed to detect CEA in serum is commercially available. At first, the investigators⁷ thought it could be utilized as a screening test for early detection of colon cancer. However, this was not the case, since elevated serum CEA levels occur in many malignant tumors, originating in the gastrointestinal tract, breast, and bronchus, as well as with diseases associated with inflammation or

regeneration.¹⁰ At present, the most useful role for serum CEA seems to be in monitoring patients during the follow-up period after surgery. Effective surgical therapy causes elevated serum CEA to return to normal levels, while subsequent rises appear to develop with tumor recurrence or spread.

Dhar, *et al.*¹¹ reported that 72 percent (57/79) of known colonic cancer patients had positive serum CEA radioimmunoassays. Only 19 percent (3/16) of those with localized tumors had a positive test, while 100 percent (18/18) with distant metastatic disease were positive. Preoperatively, undetectable CEA in patients with known colonic cancer suggested localized tumor and good prognosis. Strongly positive CEA tests in such patients correlated with extensive tumors and poor prognosis. Postoperatively, a positive serum CEA test indicated presence of residual tumor, although a negative postoperative CEA test did not exclude residual tumor. Periodic CEA determination in the patients who have undergone resection of colonic cancer may detect tumor recurrence at a treatable stage.

Immunodiagnosis of Cervical Cancers — According to Plummer and Masterson,⁹ 30 to 48 percent of the cervical cancer patients seem to have antibody against type 2 herpes virus, as compared to 9 to 18 percent of the control group. If a patient is found to have such an antibody, she may have a cervical cancer. Patients with invasive squamous cell carcinoma of the cervix have a specific, cell-mediated immune response against the carcinoma,¹² the detection of which can be used as a diagnostic method of the cancer. However, neither of these tests has any practical value, since Papanicolaou's smear and biopsy are much easier for screening and diagnosis.

The prognosis of cervical cancer after treatment may be aided by an antibody test which has been developed. According to Aurelian, *et al.*,¹³ type 2 herpes virus normally kills the infected cells in genital herpes. If the virus undergoes change, it will transform the infected cells into malignant cells instead of killing them. In such circumstances, a cervical cancer-specific antigen, designated "AG-4," will appear in the tumor

cells, and antibody to "AG-4" will be induced in the patient's serum. Antibody to "AG-4" was detected in 35 percent (7/20) of cervical atypia, 68 percent (13/19) of carcinoma *in situ*, 91 percent (20/22) of invasive cervical cancer before treatment, 0 percent (0/14) of the invasive cancer treated with radiation, and also 0 percent (0/9) of the cancer treated with hysterectomy. Follow-up of the anti-AG-4 titers after treatment with a complement fixation test may detect tumor recurrence at an early stage.

Immunodiagnosis of Ovarian Cancers — Ovarian cancers tend to develop insidiously without symptoms and are usually found too late to be cured. Culdocentesis which can be used as a screening procedure, seems to have limited value. It is desirable to develop a blood test for early diagnosis of ovarian cancers as a mass screening procedure. Ovarian cancer may shed specific antigens into the blood stream and may induce the production of specific humoral antibodies and specifically sensitized lymphocytes. If methods can be devised to detect these antigens, antibodies, or lymphocytes, they may become practical screening tests for early ovarian cancer.

Levi¹⁴ has claimed success in detecting ovarian cancer antigens and anti-ovarian cancer antibodies in patient's serum by means of immunodiffusion. Since tumor-specific antigens are believed to be located mainly on the cell membrane and are usually better inducers for cell-mediated immunity rather than for humoral immunity, detection of specifically sensitized lymphocytes may be more effective for early diagnosis of ovarian cancers.

A patient with a typhoid infection will produce anti-O antibody in his serum, which can be visualized as agglutination of salmonella bacilli in the Widal test. Similarly, a patient with ovarian cancer will produce specifically sensitized lymphocytes, which can be visualized by a test called "the leukocyte migration inhibition test."

The leukocyte migration inhibition test is clear if one understands the mode of attack which the cell-mediated immune system employs against its enemy. We can liken an ovarian cancer or a

renal graft to a castle and the cell-mediated immune system to the attacking troop. A troop consists of professional officers who are responsible for the attack, and recruited privates who prefer to escape from the battle unless there are orders from the officers to bind them together to mount an attack. Interestingly the cell-mediated immune system of our body acts in a similar way. The specifically sensitized lymphocytes are likened to the officers, and the non-sensitized lymphocytes and macrophages to the privates. The officers arrive at the battlefield first and issue "recruiting" order (chemotactic factor) to mobilize the privates. Then, the officers will constantly issue "no-escape" orders (migration inhibition factor or MIF) to bind the privates together to mount the attack.

The leukocyte migration inhibition test is the *in-vitro* version of the above. Blood is drawn from a patient and the leukocytes are separated, packed into capillary tubes and incubated in culture medium with ovarian cancer extract added as an antigen. If there are no specifically sensitized lymphocytes against the antigen, i.e., the patient does not have an ovarian cancer, the leukocytes will gradually migrate freely and spread like a flower bud at the end of the capillary. If there are sensitized lymphocytes, i.e., the patient has an ovarian cancer, the sensitized lymphocytes will be alarmed by the presence of the antigen and will promptly issue "no-escape" order (MIF) to keep the leukocytes from migrating out of the capillary, and the end of the capillary will show a compact appearance.

Chen, *et al.*¹⁵ has reported that the leukocyte migration inhibition test is really capable of detecting cell-mediated immune response in ovarian cancer patients and that common tumor antigens are present between serous and mucinous types of ovarian cystadenocarcinomas. However, this test procedure is still too tedious and complicated to be used as a screening test. A number of problems remain to be solved before a practical immunodiagnostic method can be developed for screening early ovarian cancers.

Tuberculin test is utilized to detect cell-mediated immunity against tuberculous bacilli, while the Lepromin test is used to differentiate between

tuberculoid and lepromatous types of leprosy. One may imagine that a delayed hypersensitivity skin test employing specific tumor antigens might be useful to diagnose malignancies or to predict their prognosis. Stewart¹⁶ reported that only 26 percent of cases showed a delayed hypersensitivity skin reaction toward the extract of their malignant cells. Specific delayed hypersensitivity skin test seems to be of limited value for immunodiagnosis of malignancies because of its lower precision and sensitivity than laboratory tests. One exception is a skin test with melanoma antigen which shows a correlation between a positive test and the localized nature of the disease.

Nonspecific Immunologic Skin Tests to Predict Cancer Prognosis — Eilber and Morton⁴ performed a nonspecific skin test for delayed hypersensitivity to 2,4-dinitrochlorobenzene (DNCB) and found that this test could gauge a cancer patient's general cellular immune reactivity and also predict the prognosis after surgical treatment. Fourteen days after a sensitizing dose of DNCB, a challenge dose was administered to each patient's arm. A positive skin reaction was considered the mark of a cancer survivor, since 92 percent (50/54) of patients who were free of the disease six months after surgery were DNCB positive. Among patients who were inoperable or developed early recurrence, only 7 percent (2/29) reacted to DNCB. Further study¹⁷ conducted by various investigators generally supports the view that there is a highly significant correlation between the clinical course of cancer patients and the host's cellular immune capability as shown by the skin test.

The Possibility of a Universal Immunodiagnosis for All Human Malignant Tumors? — Caspary and Field¹⁸ succeeded in extracting an encephalitogenic factor from human brain which was able to induce allergic encephalitis in guinea pigs. When the same extraction procedures were applied to human malignant tumor tissue instead of brain tissue, the authors claimed that a basic protein could be extracted which seemed to be a common antigen to all kinds of human malignancies. They stated that lymphocytes of patients with any kind of malignant tumors could be sensitized against this antigen, and that

this state of cell-mediated immunity could be detected by a "cytopherometric test." This method of assessing lymphocyte sensitization is similar to the "leukocyte migration inhibition test" in principle, and depends on the interaction of sensitized lymphocytes with specific antigen to liberate some material which has the property of slowing electrophoretic migration of normal guinea pig macrophages which are used as an indicator system. If their claim is true, this test may become an *in-vitro* screening test for all kinds of human malignancies.

Immunotherapy of Tumor

Many attempts at immunotherapy of cancer have been undertaken since the turn of the century when studies with "random-bred" laboratory animals demonstrated that strong immunity could be induced against transplantable neoplasms. There followed a period of intense laboratory and clinical investigation in tumor immunology in anticipation that these observations could lead to the control of malignant diseases. However, it soon became evident that immunity against tumors was not directed against tumor-specific antigens but against normal histocompatibility antigens carried on the tumor cells. Clinical use of immunotherapy was disappointing and soon faded away under the shadows of the more rapidly advancing surgical, radiation and chemical therapy.

Interest in tumor immunology was reawakened 18 years ago with conclusive demonstration of tumor-specific antigens in chemical carcinogen-induced neoplasms of "inbred" mice.¹⁹ These tumor-specific antigens were discovered in inbred laboratory animals because of their ability to induce rejection of tumor transplants from other members of the same inbred strain. The tumor-specific antigens of virus-induced neoplasms were common to all neoplasms induced by the same virus. In contrast, specific antigens of the neoplasms induced by chemical carcinogens were individually distinct for each neoplasm, even if induced by the same carcinogen, originating in the same animal, and of the identical histologic type. The collection of evidences that cancer growth is definitely related to immune responses of the host has led us to believe that immunotherapy will eventually become a useful new modality in cancer therapy.

Nonspecific Active Immunotherapy — One of the earliest examples of immunotherapy was conducted by Coley, an American surgeon, at the turn of the century.²⁰ He observed that an inoperable sarcoma of the neck regressed completely after two attacks of erysipelas and remained under control for seven years. Following this experience, he attempted to produce erysipelas in patients with recurrent cancer. This led him to develop Coley's mixed bacterial toxins which were injected directly into the tumor or given intravenously in some cases. Some regressions of tumors and long-term cures were reported, but the work generally went unrecognized because it was far ahead of its time.

Recent experiences with mixed bacterial toxins have not been as impressive as Coley's, but the idea has revived in the BCG therapy of malignant melanoma and acute leukemia, which so far has been the best example of successful immunotherapy. Morton, *et al.*²¹ injected BCG (*Bacillus Calmette-Guerin*, i.e., attenuated *Mycobacterium bovis*) directly into metastatic nodules of malignant melanoma. In patients whose cell-mediated immunocompetence was evidenced by a positive tuberculin test following BCG treatment, approximately 90 percent of the melanoma nodules directly injected with BCG were observed to regress. Sequential biopsies of the tumor nodules revealed that the regression was associated with a granulomatous infiltration of lymphocytes, monocytes and fibroblasts surrounding the melanoma cells. This is a "nonspecific active immunotherapy." The invasion of the mycobacteria into the body has alarmed the cell-mediated immune system to mount attack against the invader. On the way to attack the acute enemy (the mycobacteria), it encounters also the insidious enemy (the melanoma cells) which has been there for some time already.

Mathé, *et al.*²² introduced BCG immunotherapy into the treatment of acute lymphoblastic leukemia. After remission had been induced and the subclinical burden of residual leukemic cells had been reduced to a minimum by chemotherapy, they administered BCG to the patients by scarification, with or without additional vaccination with irradiated homologous leukemic cells. One hundred percent (10/10) of the control

group relapsed within 130 days after cessation of chemotherapy, while 35 percent (7/20) of the immunotherapy group were still in their first remission ranging from four and a half to seven years when reported. Other groups of investigators also reported encouraging results in the treatment of acute myelogenous leukemia by the combination of chemotherapy and immunotherapy.

Among 54,414 babies who were vaccinated with BCG after birth, there was just one death of acute leukemia at five years of age (0.31 per 100,000 per year); whereas out of 172,986 non-vaccinated black Chicago babies, 21 died of acute leukemia (2.02 per 100,000 per year) — nearly seven times as many. This suggests that BCG might be considered a vaccine against acute leukemia as well as against tuberculosis. In an analogous speculation, people who have suffered from tuberculosis might have stronger resistance against malignant melanoma and acute leukemia.

Efforts are now being made to improve the method of BCG vaccination. Vaccination with BCG cell wall fragments incorporated in mineral oil has been found to be effective in suppressing the growth of chemically-induced guinea pig hepatoma.

DNCB, the chemical used in the skin test for prediction of cancer prognosis, has also been used successfully as a nonspecific active immunotherapeutic agent in the treatment of two cases of vulvar atypia (one intraepithelial epidermoid carcinoma and one Bowenoid type severe atypia), as reported by Weintraub and Lagasse.²³ They applied a 0.1 percent DNCB preparation in an aqueous base, to vulvar lesions daily, and continued until bullous formation or superficial ulceration was noted, usually within one to two weeks. Medication was then stopped and healing was allowed to begin. Six months after the treatment, biopsies showed the vulvar lesions had reversed to squamous epithelia of orderly maturation. The value of immunotherapy in vulvar atypia awaits further evaluation, but these results suggest that this mode of therapy is worth trying before resorting to surgery in young women with localized disease.

Specific Active Immunotherapy — In the aforementioned Mathé's immunotherapy for acute leukemia, some of the patients were vaccinated with BCG and irradiated homologous leukemic cells. Vaccination of leukemic patients with leukemic cells is "specific active immunotherapy." So far, most attempts at specific active immunotherapy in man used vaccines composed of inactivated human tumor cells. Immunizing man with human tissue is called "homologous immunization," which is usually not as effective in inducing immune responses as heterologous immunization, as with BCG for example. Efforts to increase the antigenicity of tumor vaccines by modifying tumor cells include attaching autologous tumor cell to rabbit gamma-globulin, which serves as a heterologous carrier protein, or pretreating the tumor cells with neuraminidase, which can strip off sialic acids in the cell's sialomucin coating to expose the antigenic sites on the cell membrane. The ideal tumor vaccine would be composed of isolated and purified tumor-specific transplantation antigens from cell membrane. Such preparations would have the advantage of safety, stability, and ease of administration. To date, there has been little progress made in the isolation and purification of human tumor-specific antigens. Another problem in specific active immunotherapy of tumor is that of "enhancing antibody." The immunotherapy will induce humoral antibody production as well as specific cell-mediated immunity; so far, it is still unclear if the humoral antibody always will act against the tumor, or under some circumstances, against the host also.

Passive Immunotherapy — One of the earliest and most impressive examples of passive immunotherapy was reported in 1960 by Sumner,²⁴ who treated a melanoma patient by transfusing 250 milliliters of whole blood from a second melanoma patient, who had undergone a spontaneous remission. Following this transfusion, the treated patient also underwent spontaneous remission. This method, however, was unsuccessful on other occasions.

Treating tumor patients with anti-tumor antibodies produced in human or animals represents an attempt at passive immunotherapy. Patients with growing tumors

tend to have enhancing or blocking antibodies in their serum, while patients who have been cured of their malignancy demonstrate high titers of cytotoxic or unblocking antibodies. The serum of the latter may be utilized in cancer immunotherapy as in the aforementioned case of melanoma. Anti-tumor sera from animals injected with human tumor cells are too toxic to be used because they contain antibodies against normal human tissue antigens. When successful isolation and purification of the tumor-specific antigens are achieved and the puzzles concerning the role of humoral antibody in the fight against tumor are solved, this approach may become practical.

Since cell-mediated immunity is thought to be the chief immune mechanism to destroy cancer cells, transfusing lymphoid cells might be considered the main channel to passive immunotherapy. However, transfusing lymphoid cells is a kind of transplantation of a homologous tissue graft which will be rejected by the host sooner or later due to their different histocompatibility antigens. This problem can be overcome when lymphoid cells are obtained from identical twins or siblings identical by HLA (human leukocyte antigen) matching, or by bulk growth of the patient's own lymphocytes in tissue culture. In human sarcomas, a high incidence of anti-tumor antibodies has been found in the close family members of the patient. Lymphocytes of the family members may already be sensitized to the tumor-specific antigens, so there is a possibility that human sarcomas may be treated by passive immunotherapy with lymphocytes from well-matched family members. Specific sensitization of autologous lymphocytes against tumor antigens by *in-vitro* cultivation of the lymphocytes with mitomycin C-treated cultured tumor cells has also been attempted. Mitomycin C prevents replication of tumor cells in such a way that their potential to form metastases is eliminated when they are re-infused into the patient along with the sensitized lymphocytes. The results of this type of therapy have not been impressive thus far, but animal experiments suggest that it is promising.

A particularly appealing method of passive immunotherapy involves the transfer of informational molecules that have the ability to in-

duce a specific cellular immune response in the recipient's immune effector system. Transfer factor and immune RNA (ribonucleic acid) are two presently known substances having such activity. Lawrence's transfer factor is capable of transferring immunity to skin graft, tuberculosis, and a variety of other antigens in human. Currently it is under investigation for its possible usefulness in human cancer immunotherapy. The method of passive immunotherapy employing immune RNA will work as follows. Animals will be immunized with human tumor-specific antigens, and then immune RNA will be extracted from the animal's lymphoid tissue and administered to patients to convert their "normal" lymphocytes into "killer" cells against the tumor.²⁵

Miscellaneous Immunotherapy — There are other approaches to immunotherapy of tumors. Folkman²⁶ showed that a solid clump of malignant cells exudes a "tumor angiogenesis factor" (TAF) which summons the growth of capillary vessels to it. Without capillary ingrowths summoned by TAF, a solid tumor can grow only until its size reaches 0.8 millimeter in diameter, which is the limit at which a tumor can survive with only the process of diffusion supplying nutrients and disposing of catabolites; it will remain dormant at that size. If anti-TAF antibody can be produced and administered to patients with solid tumor, it will be able to stop capillary ingrowths to the tumor and make it dormant. The current problem is the fact that TAF does not appear to be species-specific, and it is difficult to produce anti-TAF antibody in animals. TAF should somehow be made antigenic to produce anti-TAF in animals, which in turn could be used to make human solid tumors dormant. The malignancies most appropriate for treatment with anti-TAF would be the most vascular-dependent ones such as brain tumors, while the least appropriate might be something like a chondrosarcoma which is nearly avascular.

A thymus-derived lymphocyte-stimulating hormone has been discovered and named "thymosin." Thymosin is said to be a T-cell recruiting factor which presumably can bolster cell-mediated immunity. If it proves to be true, thymosin also will find a place in the immunotherapy of tumors.

Choriocarcinoma is a rare malignancy which, even when disseminated, can be cured by chemotherapy alone. Since this tumor is of fetal origin, it is in essence a homograft; one must speculate that immunologic rejection may be involved in its unique response to chemotherapy. Possibly, the chemotherapeutic agents destroy both the gross tumor and the immunologic barrier, and then, the graft rejection leads to the complete cure. It is interesting to note that primary choriocarcinoma of the ovary, although histologically identical to gestational choriocarcinoma, is particularly unresponsive to chemotherapy. There are also interesting reports on the immunotherapy of choriocarcinoma. A patient with choriocarcinoma experienced apparent complete regression of her tumor after she was treated with repeated injections of her husband's sperm and antiserum from animals hyperimmunized to her husband's sperm. Doniach, *et al.*²⁷ reported the cure of a patient with this disease who had been immunized with her husband's leukocytes and repeated skin grafts.

*The Necessity for Combined Modalities in Cancer Therapy*²⁸ — There is a certain quantitative relationship between the size of tumor and host immunity. In human autograft experiments with cancer cells, inoculation with 100 million (10^8) cells always produced a nodule, whereas that with 10 thousand (10^4) cells invariably failed to do so, and "takes" of tumor autograft depended on the state of immunologic resistance in the host when the intermediate cell numbers (10^5 to 10^7) were employed. Tumor immunity can thus be overcome by a sufficiently large tumor mass. Given this fact that the size of the tumor is critical in host anti-tumor resistance, immunotherapy is effective only when the tumor size is relatively small, say 100 thousand (10^5) to one million (10^6) cells or less. There is general agreement that when it reaches a size of one billion (10^9) or more cells, it is beyond control through the capacity of immunologic resistance. A neoplasm of one centimeter in diameter contains approximately one billion (10^9) tumor cells.

The above facts clearly show that there is a relatively low ceiling on the maximal tumor

burden approachable by immunotherapy. Superficially, one might conclude that at best immunotherapy can have only a limited, unimportant role in the treatment of advanced clinical cancer. This thesis, however, does not stand up on closer analysis. Immune mechanisms and immunotherapy are in fact central to the successful treatment of cancer, and unless they play a part, established malignant diseases are simply not curable. Surgery, radiotherapy and chemotherapy can eliminate 90 percent or even 99 percent of a cancer, but they often fail to eradicate the cancer and recurrence occurs. Immunotherapy is unique in being able to clean up the residual cancer and to kill the last cancer cell.

Here arises the necessity to combine modalities in cancer therapy. At first, surgery and/or radiotherapy may be employed as the means to reduce spontaneous tumor size to the range of optimal chemotherapeutic effect. Since antigen excess may suppress immune reactivity in the host, surgical removal of bulk antigenic tumor mass can also remove a state of immunologic inertia and make the host's immunologic system receptive to immune stimulation. As the next step, chemotherapy can be employed to bring the tumor cell numbers down to, or below, the relatively low ceiling of the maximal tumor burden approachable by host immune mechanisms and/or immunotherapy. For a given form of chemotherapeutic treatment, the percent reduction of neoplastic cells, not the number of cells reduced, is constant regardless of the number of tumor cells present at the time treatment was initiated. Therefore, the lowest number of neoplastic cells is achieved by initiating chemotherapy at a time when cancer cells are fewest. Hence, chemotherapy should be most effective following reduction of bulk tumor by either excisional surgery or cell-destroying radiotherapy. However, all anticancer drugs are toxic to the host, and toxicity invariably supervenes well before the number of cancer cells can be drug-reduced to the last cancer cell. An intermittent treatment schedule can allow host recovery without proportionate recovery of the tumor cell population. Higher concentrations of drugs may be employed with resultant increase in therapeutic effect. Toxicity may

also be ameliorated by employing combination chemotherapy. Combinations of two or more drugs with different fundamental mechanisms of action can permit greater effect against a tumor without a corresponding increase in toxicity. Finally, when the tumor is brought down into the range of effective immunotherapy, immunotherapy should be employed to destroy all of the cells in the cancer population and lead to complete cure.

Immunotherapy of cancer is still in a primitive stage. The rational application of immunotherapy to human cancer will depend upon a better knowledge of the nature of the tumor-specific antigens in human neoplasms and methods for increasing the immune response against these antigens. It has been demonstrated that enhancement of a tumor growth can occur when immunotherapy is applied inappropriately in animal experiments. In order to avoid this, it is necessary to define by laboratory study those immune responses that best correlate with clinical course and then develop immunotherapy programs to stimulate those responses in cancer patients. The future of immunotherapy in human cancer is bright, and results will improve as this knowledge grows.

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100 Bergen Street, Newark

Pathology (Rheumatoid Factor Test)—Stanley Burrows, M.D.*

A serologic test for rheumatoid factor in an elderly patient with vague muscle and joint "aches" is reported as positive to a titer of 1:40. This result: (a) Confirms the diagnosis of rheumatoid arthritis, (b) Rules out rheumatoid arthritis, (c) Means nothing, or (d) Requires further information for interpretation

Answer — (d) Requires further information for interpretation — Unfortunately, most tests for rheumatoid factor (RF) lack specificity for rheumatoid arthritis. The original Rose-Waaler test using sensitized red blood cells was developed as a relatively specific test for rheumatoid arthritis, but it lacks sensitivity and is difficult for performance in the average clinical laboratory.

Latex particle tests provide a simple test for RF, but at the sacrifice of specificity. This results in a positive latex test in up to 45 percent of patients with diseases other than rheumatoid arthritis. This false positive rate has been reduced to only 8 percent by prior heating of the serum at 56 degrees C. for 30 minutes to destroy comple-

ment. Additional specificity is possible by performing the test on dilutions and reporting the highest dilution with a positive result. The higher the titer, particularly 1:80 and higher, the more likely that the test is specific for rheumatoid arthritis.

The recent commercial availability of a rapid slide test (Rheumaton) using a relatively stable preparation of aldehyde treated sheep red blood cells coated with rabbit amboceptor provides a test with the smallest number of false positive

results (3 percent), compared to the latex titration test (9 percent), the Rose-Waaler test (13 percent) and the latex slide test (14 percent). Because of its greater specificity, a positive reaction at even as low a titer as 1:10 is significant.

At Cooper Hospital, we routinely perform both the latex titration test and the Rheumaton slide test, so as to offer both high sensitivity and specificity. Proper interpretation of a test for RF will depend upon the methods used, which will vary among different hospital laboratories. In addition, some patients with rheumatoid arthritis have negative tests for RF. Patients with rheumatoid arthritis who have positive tests for RF have a greater prevalence of rheumatoid nodules, greater severity of x-ray changes in small joints, and worse prognosis than matched seronegative patients in regard to functional capacity, joint erosions, and number of involved joints.

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She's a vice president of a publishing company.

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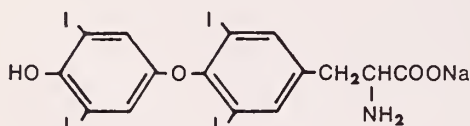
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Thyroid replacement may potentiate the effects of anticoagulants. Patients on anticoagulant therapy should have frequent prothrombin determinations when instituting thyroid replacement to gauge the need to reduce anticoagulant dosage.

Precautions

Overdosage with any thyroid drug may produce the signs and symptoms of thyrotoxicosis, but resistance to such factitious thyrotoxicosis is the general rule. With SYNTHROID (sodium levothyroxine) **Tablets**, the relatively slow onset of action minimizes the risk of overdose but close observation in the weeks following institution of a dosage regimen is advised. Treatment of thyroid hyperactivity induced by oral medication is confined to interruption of therapy for a week, followed by reinstitution of daily therapy at an appropriately reduced dosage.

Adverse reactions

Adverse reactions are due to overdose and are those of induced hyperthyroidism.

Dosage and administration

For most adults, a final dosage of 100 mcg (0.1 mg) to 200 mcg (0.2 mg) of SYNTHROID (sodium levothyroxine) **Tablets** daily will restore normal thyroid function and only occasionally will patients require larger doses. Failure to respond adequately to a daily oral intake of 400 mcg (0.4 mg) or more is rare and should prompt reconsideration of the diagnosis of hypothyroidism, special investigation of the patient in terms of malabsorption of L-thyroxine from the gastrointestinal tract or poor adherence to therapy.

The concomitant appearance of other diseases, especially cardiovascular diseases, usually dictates a replacement regimen with initial doses smaller than 100 mcg/day (0.1 mg).

In otherwise healthy adults with relatively recent onset of hypothyroidism, full replacement dose of 150 mcg (0.15 mg) or 200 mcg (0.2 mg) has been instituted immediately without untoward effect and with good therapeutic response. General experience, however, favors a more cautious approach in view of the possible presence of subclinical disorders of the cardiovascular system or endocrinopathies.

The age and general physical condition of the patient as well as the severity and duration of hypothyroid symptoms determine the starting dosage and the rate of incremental dosage increase leading to a final maintenance dosage. In the elderly patient with long standing disease, evidence of myxedematous infiltration and symptomatic, functional or electrocardiographic evidence of cardiovascular dysfunction, the starting dose may be as little as 25 mcg (0.025 mg) per day. Further incremental increases of 25 mcg (0.025 mg) per day may be instituted at three to four week intervals depending on patient response. Conversely, otherwise healthy adults may be started at higher daily dosage and raised to the full replacement dosage in two to three weeks. Clearly it is the physician's judgment of the severity of the disease and close observation of patient response which determines the rate of dosage titration.

Laboratory tests to monitor thyroid replacement therapy are of limited value. Although measurement of normal blood levels of thyroxine in patients on replacement regimens frequently coincides with the clinical impression of normal thyroid status, higher than normal levels on oral replacement of levothyroxine occasionally occurs and should not be considered evidence of overdosage per se.

In all cases, clinical impression of the well-being of the patient takes precedence over laboratory determination in determining the appropriate individual dosage.

In infants and children, there is a great urgency to achieve full thyroid replacement because of the critical importance of thyroid hormone in sustaining growth and maturation. Despite the smaller body size, the dosage needed to sustain a full rate of growth, development and general thriving is higher in the child than in the adult, as much as 300 mcg (0.3 mg) to 400 mcg (0.4 mg) per day.

In myxedema coma or stupor, without concomitant severe heart disease, 200 to 500 mcg of SYNTHROID **Injection** may be administered intravenously as a solution containing 100 mcg/ml. Although the patient may show evidence of increased responsiveness within six to eight hours, full therapeutic effect may not be evident until the following day. An additional 100 to 300 mcg or more may be given on the second day if evidence of significant and progressive improvement has not occurred. Like the oral dosage form, SYNTHROID **Injection** produces a predictable increase in the circulating level of hormone with a long half-time. This usually precludes the need for multiple injections but continued daily administration of lesser amounts intravenously should be maintained until the patient is fully capable of accepting a daily oral dose.

In the presence of concomitant heart disease, the sudden administration of such large doses of L-thyroxine intravenously is clearly not without its cardiovascular risks. Under such circumstances, intravenous therapy should not be undertaken without weighing the alternative risks of the myxedema coma and the cardiovascular disease. Clinical judgment in this situation may dictate smaller intravenous doses of levothyroxine.

SYNTHROID **Injection** by intravenous or intramuscular routes can be substituted for the oral dosage form when ingestion of SYNTHROID **Tablets** is precluded for long periods of time.

How supplied

SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in 6 concentrations: 25 mcg (0.025 mg)—orange . . . 50 mcg (0.05 mg)—white . . . 100 mcg (0.1 mg)—yellow . . . 150 mcg (0.15 mg)—violet . . . 200 mcg (0.2 mg)—pink . . . 300 mcg (0.3 mg)—green. Depending on strength, these tablets are available in bottles of 100, 500, 1000 and 5000.

SYNTHROID (sodium levothyroxine) for **Injection** is supplied in 10 ml vials containing 500 mcg of lyophilized active ingredient and 10 mg of Mannitol, U.S.P. A separate 5 ml vial containing Sodium Chloride Injection, U.S.P. is provided as a diluent.

Directions for reconstitution

Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml of the Sodium Chloride Injection, U.S.P. to the vial. Shake vial to insure complete mixing. **Use immediately** after reconstitution. Discard any unused portion.



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Many infections cannot be prevented because of inherent factors. However, with an organized Infections Committee and thorough surveillance, a good microbiological laboratory, continuing education of the medical, dental, and nursing staffs, and a diligent hospital administration, infective situations may be identified and attempts can be made to prevent and correct hospital-acquired infections.

Nosocomial Infections*

Dominic A. Mauriello, M.D.
Jersey City

Fifteen percent of all hospital patients have infections; five percent of these patients acquire their infection in the hospital. Among "untoward reactions" in Grace-New Haven Hospital in 1964, nosocomial (hospital-acquired) infections ranked second in prevalence, but first in mortality.¹ Lorian² found that the death rate in a group of patients with nosocomial infections was 23 percent as compared with 4 percent in the general hospital population. Aside from the increased mortality and morbidity, this problem is associated with tremendous financial cost. If one accepts the postulates that (1) a nosocomial infection extends a hospital stay for two days, (2) the number of hospital patients in the United States on any day is 31 million, of which 5 percent will develop infection, and (3) the "average" daily hospital charges are \$150, then one must conclude that there is an extra cost of \$450 million for each hospital-acquired infection. It is clear that "infective situations" are everywhere in the hospital, posing a threat to everyone — patients, personnel, and visitors. Many problems are obvious but many others are subtle and not easily identified. Even if identifiable, it may be impossible to control them adequately. The purpose of this paper is to point out and to discuss the diverse factors which predispose to infections and "infective situations" and to indicate what measures are necessary to prevent and control the problem.

Causes of Nosocomial Infections

There are so many causes for hospital-acquired infections that only the most prevalent ones will be discussed.

Airborne infection of surgical wounds — By and large, wound infections occur in the operating room and are due to many factors. Personnel may be at fault because of (1) inadequate surgical scrub, (2) harboring infection themselves, (3) excess motion in the operating room, and (4) improper garb. Equipment may be improperly maintained or poorly sterilized. The patient himself may be in a contaminated state. Cardiovascular and orthopedic operations predispose to infection because of the prolonged time of surgery. Animal experiments have shown that operating rooms with laminar flow have lowered air-contamination tenfold,³ but it is still debatable as to which aseptic control measures result in lowered rates of postoperative wound infection.

Inadequate Sterilization — Disposable needles and syringes have made hepatitis less a hospital problem, but contaminated intravenous solutions, catheter equipment and inhalation therapy machines present untoward situations because they may be marketed in a contaminated condition or they may be improperly sterilized within the hospital.

Foreign bodies — Present hospital care requires the use of catheters and indwelling tubes for alimentation and suctioning, pacemakers, arterial grafts, prosthetic valves, and other devices of "medical progress." They are life-saving but their very usage can produce infections,⁴ the added factors of prolonged use and poor handling can increase the infection rate by as much as two-thirds.

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Misuse of Antibiotics — Through their selective effect on normal flora, antibiotics can predispose to superinfection by endogenous organisms. Louria⁵ did sputum colony counts on patients receiving various combinations of antibiotics and reported the following figures for sputum superinfection:

<i>Antibiotic Regimen</i>	<i>Percent Superinfected</i>
Penicillin (1.2-2.4 million units)	0%
Tetracycline or Chloromycetin	4.5%
Penicillin + Streptomycin	16.7%
Penicillin + Tetra or Chloro	42.9%

Some of these superinfections were manifest clinically, whereas many more merely represented colonization of the respiratory tract without actual disease.

In addition to overuse, their improper use permits the hospital environment to become contaminated by traces of antibiotics, as with ointments which are of some effect in pyogenic and some fungal dermatoses, but less so in infected decubiti. Another consequence of overuse is the fact that bacterial strains become resistant and then transfer their resistance genetically to other strains, e.g., transfer of "R-factor" from one coliform to another.

The general principles for avoiding drug resistance and for sound antibiotic usage have been promulgated by Sherris as follows:⁶

1. Limit antibiotics to essential use only.
2. Restrict chemoprophylaxis to a few accepted situations.
3. Treat with adequate dosage and for sufficient time.
4. Avoid routine use of combinations of antibiotics.
5. Select antibiotics on the basis of *in-vitro* tests if possible.
6. Avoid environmental contamination with antibiotics.
7. Avoid cross-infection.

Changing Pathogens — Our major problems are due to organisms that are endogenous, that is, on or in the patient; these have replaced the staphylococcus of 25 years ago, which replaced the streptococcus of 50 years ago. It is possible for micro-organisms to adjust or become replaced without relation to antibiotic usage. Problems in treating these superinfections may result from severe underlying disease or the dangerous effect of potent antibiotics on various organs such as the kidney, liver, bone marrow, and so on.

Nevertheless, the following table indicates the prevalence of nosocomial bacterial pathogens. It should be noted that surveillance of other pathogens, especially viruses, is very unsatisfactory, and therefore not categorized in most studies.

Nosocomial bacterial pathogens — 21,972 cultures⁷

<i>Gram-positive:</i>	Total: 33%
S. aureus	13%
Staphylococci, all others	7%
Streptococcus, beta-hemolytic	3%
Streptococci, all others (e.g. enterococcus)	10%
All other gram positives	0%
<i>Gram-negative:</i>	Total: 67%
E. Coli	24%
Proteus, indole-negative (mirabilis)	9%
Proteus, indole-positive	3%
Pseudomonas aeruginosa	9%
Klebsiella pneumoniae	2%
Klebs-enterobacter-serratia	6%
Klebsiellae, all others	7%
All other gram-negatives	7%

Staphylococcus — Many studies have been done on hospital infections caused by *S. aureus*. Clearly, this organism has a human source — hands, skin, nose and so on — and is transferred from patients, personnel and visitors to each other. Although it is important to segregate the patient with a contaminating *S. aureus* infection, handwashing is the single most important method of prevention. Staphylococcal infections can be critical in a children's nursery; in fact, almost all babies become nose and skin carriers a few days after birth. As many as 10 percent of newborns will develop infection from infected mothers' breasts, as well as from other infants and personnel. Masks and gowns make little difference. Hexachlorophene bathing curbs staphylococcal infection; however, neonates may absorb the drug through the skin resulting in brain damage. Experimentally, rats fed hexachlorophene and newborn monkeys bathed with a 3 percent emulsion for 90 days all developed serious brain injury. In France, 30 infants died when bathed accidentally with a powder containing 6 percent hexachlorophene.⁸ These experimental and clinical experiences have compelled the Federal Drug Administration to direct hospitals to confine hexachlorophene to prescription use. The following are acceptable uses:

1. Personnel hand washing.
2. Soaking infected areas of the body of the patient.
3. Baby-bathing with 3 percent pHisoHex twice only during nursery epidemics.

Streptococcus — Group A beta-hemolytic streptococcus is an occasional problem, especially in obstetrical patients.⁹ At times this organism may be a source of intravenous-catheter infections. Group B hemolytic streptococcal infections of late onset in the neonate (over 10 days) are of nosocomial origin. Penicillin is the drug of choice since the 20 percent resistance rate to tetracyclines makes the latter a poor choice. The enterococcus, which behaves as a gram-negative organism, is more troublesome, and virtually always results from urethral instrumentation; it less frequently comes from abdominal and pelvic disease.

E. coli — Although it is a common spontaneous cause of pyelonephritis in the female, *E. coli* is the most common nosocomial pathogen, usually causing infection after instrumentation. The enteropathogenic strains produce disease in another setting, the nursery; as with the *S. aureus*, the neonates become nasal carriers infected by careless personnel who neglect handwashing.

Proteus — Although proteus infections are difficult to survey, in the absence of accurate strain differentiation, speciation is possible and important. The indole-negative species (*mirabilis*) is sensitive to penicillins and cephalosporins. The indole-positives (*morgagni*, *vulgaris*, *rettgeri*) are resistant to these antibiotics, but are sensitive to aminoglycosides, chloromycetin, and carbenicillin. The organism frequently arises from the urinary tract and causes bacteremias with mortality as high as 70 percent in some groups of patients with severe underlying disease.

Pseudomonas — *Ps. aeruginosa* accounts for about 10 percent of hospital-acquired infections; they are difficult to treat and also have a high mortality. It has been notorious for causing infection in neonates, prematures, burn patients, and in immunologically deficient patients. Now, however, it is a significant cause of infection in the urinary tract and lungs, as a result of instrumentation in the former and of con-

taminated inhalation therapy equipment in the latter; this organism can survive and even multiply in moist areas. Of the many species of pseudomonas, one thinks of only three — *ps. aeruginosa*, *ps. pseudomallei*, *ps. mallei* — as causing disease. Recent experience has indicated that less common species are disease-producing; during a 20-month period ending in 1973, we encountered 18 cases of pseudomonas cepacia bacteremia in our hospital.

The source was never identified in spite of extensive search on two occasions with the help of the New Jersey State Department of Health; fortunately, the problem finally disappeared spontaneously. However, several features were apparent: (1) the infections were hospital-acquired, (2) most of the patients had compromised immunity, (3) all had received intravenous feedings, (4) the antibiogram was characteristic: *in-vitro* sensitivities showed sensitivity to chloromycetin and sulfa with resistance to all other drugs including gentamycin, carbenicillin, and polymyxin, and (5) the mortality was high — 72 percent. There is some indication that trimethoprim-sulfamethoxazole may be an effective antibacterial¹⁰ although it failed in a few of our patients who were desperately ill.

Klebsiella — Although uncommon as a nosocomial pathogen, this organism causes disease of the urinary tract (type 2), and even less often, in the respiratory tract (types 1, 3, 4 and 5). It can be studied epidemiologically by capsular typing so that the reservoirs (inhalation therapy equipment, hand lotion, zephiran chloride, and so on) can be located.

Enterobacter — These organisms are difficult to identify and to treat; they act like klebsiella, which, with enterobacter, and serratia form a division of enterobacteriaceae. The 1970-1971 nationwide experience, wherein over 500 cases of bacteremia occurred when plant organisms contaminated the screw caps of intravenous solution bottles, showed that any organism has the potential to be pathogenic.¹¹

Serratia — *S. marcescens* was also considered to be non-pathogenic, but it can cause a mortality up to 40 percent depending on the underlying factors, such as diabetes, malignancy, cor-

ticosteroid administration, and massive antimicrobial therapy. It is completely nosocomial, being related to intravenous catheters and especially urethral catheters. The organism is transmitted from one catheter patient to another so that it is imperative for personnel to wash their hands before and after caring for patients with catheters. These bacteria have been sensitive to gentamicin and resistant to cephalosporins; however, gentamicin-resistant strains are becoming more frequent. In our hospital, these strains are still sensitive to trimethoprim-sulfamethoxazole.

Salmonella — These organisms are commonly present in animals (30 percent in fowl) and in humans (1 percent) so that contamination of food from the former and poor personal hygiene by the latter can cause hospital epidemics, especially in nurseries where half the deaths occur. Salmonella infections are more prevalent in patients with malignancy (depressed resistance from T-cell dysfunction) and gastrectomies (lack of hydrochloric acid).

Mycoses — The increase in opportunistic fungal infections is due to a decrease in host resistance from disease or drug therapy and to heavy and prolonged use of broad-spectrum antibiotics. Candidiasis is a particular problem with hyperalimentation.

It should be clear then that the major pathogens are gram-negatives, and also that any so-called non-pathogen can be pathogenic and life-threatening in the right host and at the right time.

Clinical Aspects of Nosocomial Infections

Nosocomial infections mainly occur in the urinary tract and respiratory tract, and after surgery, in that order of frequency.

Urinary tract infections (UTI) — The catheter is used in 10 percent of hospital patients and is the single most important and preventable cause of serious gram-negative infection, causing a pattern of urinary tract infections, sepsis, shock and death.¹² Contamination of the bladder urine may occur as follows: (1) introduction of infection at the time of catheterization, (2) retrograde

infection up to the drainage tube, from a collection tube which is contaminated, (3) contamination when the collecting line is broken, and (4) periurethral contamination along a dirty catheter. Prevention can be obtained by (1) avoiding the catheter, (2) closed drainage or (3) a 3-way catheter with an antibiotic rinse. Nonetheless, after 7 to 10 days, *all* indwelling catheters promote infection to some degree. Unhappily, chemoprophylaxis does not work against gram-negative organisms.

Respiratory infections — Their prevalence is second to urinary tract infection. Sputum cultures may merely indicate colonization rather than infection; transtracheal aspiration can clarify the question. One should consider *S. aureus* in hospital pneumonia, especially after the use of tetracyclines or ampicillin.

Gram-negative pneumonias occur as a result of inhalation therapy, tracheostomies, nasogastric intubation and heavy use of broad spectrum antibiotics.¹³ It is now being emphasized that anaerobes are a significant cause in aspiration pneumonia with rates as high as 50 percent.¹⁴ Although clindamycin is popular (and effective), penicillin G and chloromycetin are equally as effective.

Surgical infections — Healthy tissues resist infection and hematomas, edema, necrosis, foreign bodies, and diminished host susceptibility all predispose to infection. Altemeier¹⁵ has shown the effect of predisposing metabolic and nutritional factors on wound infection in the following table:

Factor	No. of Wounds	Percent of Incidence of Infection
None	14,800	7.1
Diabetes M	356	10.4
Corticosteroids	119	16.0
Severe obesity	166	18.1
Severe malnutrition	67	22.4
Unknown	129	9.3

Chemoprophylaxis has no effect in preventing surgical infection, with the possible exception of staphylococcus in cardiac and bone surgery; non-absorbable amino-glycosides are given orally to prevent peritoneal contamination from bowel resection.

Determinants of Nosocomial Infections

In the causation of nosocomial infections, there are many determinants which reflect the patient's underlying disease plus the requirements for treatment whether it be medication or instrumentation.

Age — The diseases that go with age are more important than age itself.

Diabetes Mellitus — Carbohydrate control is desirable but the level of blood sugar is not critical. Acidosis and renal insufficiency impair granulocytic response; acidosis promotes mucormycosis; the advanced vascular insufficiency in diabetes predisposes to staphylococcal infections.

Corticosteroids — They do suppress immune mechanisms, although the exact manner is not known. They inhibit inflammation and granuloma formation and they stabilize lysosomal membranes thereby preventing enzyme release necessary for phagocytosis. Well known is the devastating steroid effect on inactive tuberculosis and other infections which are being promoted and masked at the same time, thus placing the patient in double jeopardy.

Cardiovascular — Impaired tissue perfusion permits greater pathogenicity, even of otherwise harmless bacteria. Hospital-acquired endocarditis has increased in incidence following the rise in hospital-acquired bacteremias.

Respiratory — As mentioned earlier, pulmonary infections can arise from inhalation therapy machines, especially those with reservoirs,¹⁶ and as superinfections after massive antibiotic therapy. Patients with chronic lung disease are prone to superinfections; alcoholics have decreased clearing of proteus in the tracheobronchial tree.

Cutaneous — Patients with burns, decubitus ulcers, and exfoliative diseases are all susceptible to staphylococcus and pseudomonas; reverse isolation is necessary in patients with burns and exfoliative diseases.

Neurological — Patients with disabling neurological disorders are prone to infected

“bed sores” and to hypostatic pneumonia and have an increased need for urethral catheters and other instrumentation; all of this promotes infections.

Hematological and Immunological defects — They predispose to opportunistic infections with fungi, parasites (especially pneumocystis carinii), listeriosis, and cytomegalic virus. The need for corticosteroids in these patients whose immune reaction is already suppressed, further increases the risk of severe infection.

Viral hepatitis — The virus of hepatitis endangers patients and hospital personnel. Infected blood specimens require special handling and should be so marked, while patients should be segregated. Hemodialysis patients and professional personnel are a high-risk group which requires special precautions and rules. For blood transfusion, packed washed cells should be used to minimize the incidence of type B hepatitis. The use of gamma globulin is acceptable to abort type A hepatitis and may help to prevent non-parenteral type B hepatitis.¹⁷

Urethral catheter — The catheter can cause nosocomial infections, but the main determinant is the basic need or the pre-existing disease. One should remember to culture the urine when initial catheterization is done. There is a one percent contamination rate with one catheter insertion; after 7 to 10 days of an indwelling catheter drainage, superinfection occurs even with a closed system with or without an antibiotic rinse. Proper maintenance is essential, but uniformly neglected.

Foreign bodies — Prostheses, catheters, and newer instrumentations injure tissues and thus set up areas of infection. These are “diseases of medical progress.”

Intravenous plastic catheters — In spite of aseptic precautions, after 48 hours of usage, perivenous areas become infected. A butterfly #20 needle is satisfactory for all infusions except blood. The skin area should be kept clean with or without an antibiotic ointment topically. Commercial intravenous cannula sets may be contaminated. In a recent experience with sets from one company there was a six percent contamination rate and a 17 percent prevalence of

phlebitis as compared to four percent for other manufacturers.¹⁸ To prevent such infection one should avoid intravenous therapy when possible, use aseptic precautions at all times, and change the intravenous site after 48 hours when feasible.

Hospital Infections Committee

For the prevention and control of hospital infections, good surveillance is imperative; good surveillance begins with a well-organized, properly run infections committee. The chairman should be a clinician with a strong interest in infectious diseases so that he may act as the hospital epidemiologist. An infections surveillance nurse is a necessity in order to collect information prospectively and retrospectively; she is responsible for day-to-day investigations of infections, data on antibiotic usage, significant bacterial cultures, and so on. The committee should include representatives from hospital administration, the clinical departments, the laboratory (microbiologist), the nursing service, operating room supervisor, pharmacy, food service, maintenance, and house-keeping.

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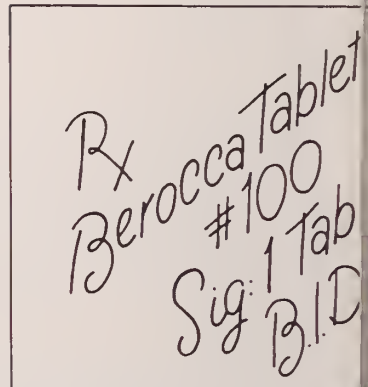


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Adoption and Its Influence During Adolescence

A Comparison of Court and Community-Referred Psychiatric Patients

**Jerome D. Goodman, M.D., and
Rena Magno-Nora, M.D./Paramus***

Literature concerning psychiatric problems for adopted children crested in the first part of the 1960's with a series of studies relating to their vulnerability.^{1,2} Perhaps three areas of investigation pertinent to psychiatry and adopted children have been subject to more scrutiny than others. The first area concerns the findings of higher incidence and risk for psychiatric illness in adopted children.^{3,4} In a study comparing extra-familial (EFA) and intra-familial (IFA) adopted children, Goodman, *et al.*⁵ concluded that the over-representation found in their study was not of a magnitude warranting social consequence. In this study, Goodman noted that not all adoptions carried similar psychological and social implications (e.g., the adoption of a step-child at age eighteen versus the adoption of the new born child of a stranger). Sweeny⁶ and later Jameson⁷ indicated that the percentage of adopted children at risk varied from 2.4 to 13.3 percent of clinical case loads. Child guidance clinics saw the fewest adopted children whereas private practice representation was considerably higher. Wherever mentioned, with one exception,⁸ studies tended to confirm that EFA children placed for adoption older than infancy presented higher clinical risk.

The second major area of research for psychiatric consequences in adoption related to follow-up studies. Kirk, *et al.*⁹ considered the pitfalls of some of this research. They concluded that: "The research designs that lend themselves

to the investigation of differential prevalence and incidence are epidemiologically based." Bratfos, *et al.*¹⁰ carried out retrospective studies in Norway as to the number of adopted children in the general population. Bratfos was able to exclude many variables such as IFA children. He found that the incidence of mental retardation was lower among adopted children, but psychotic illness (largely schizophrenia) and alcoholism occurred in the expected representation of adopted children. Anti-social activity, on the other hand, as measured by the number of adopted children registered in police files did show some over-representation.

The third area of interest in research concerning psychiatry in adopted children has to do with an attempt to delineate the type of psychopathology that may present in the adopted children who are referred. Humphrey and Ounsted^{11,12} found that symptoms and behavior problems of children adopted after the age of six months showed a significant trend toward anti-social conduct. The two most common variables they found associated with later problems for the children involved the advanced age of the parents (mother adopting at age 30 or more) and mis-handling or failure to disclose the adoption to the child, two factors that effect inculcation of conscience. Simon and Senturia¹³ discovered that EFA children differ considerably in their diagnostic composition from a controlled sample of similar referrals of non-adoptive subjects.

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They found that specific types of emotional disturbances, notably personality disorders, occurred with much higher frequency than other types among the adoptees in their sample. They also found that emotional disorders appeared to manifest themselves quite early in the life of the adoptee. Their data raised the question as to why personality disorders, especially those with anti-social symptoms, appeared with such high frequency among the EFA group. They implicated unconscious factors on the part of the adoptive parents, including postulated aversion to parenthood and living through the child vicariously. They criticized the prevalent custom of telling the children the special or "chosen child" story. Simon and Senturia considered the child's intrapsychic contribution to the problem as centered about the child's questions of biological parents and why they abandoned him. They postulated a depressive core underneath the presenting sociopathic phenomenology. They also mention the special importance of adolescence to the adopted child as a period which allows him actively to embark upon the search for his biological parents. Menlove¹⁴ found that hyperactivity, hostility and negativism were found more frequently in an adopted group as compared to non-adopted children. Offord, *et al.*¹⁵ considered whether clinical symptoms differ between emotionally disturbed adopted and non-adopted children. They found that adopted children were seen more commonly for a variety of behavioral problems representing more severe anti-social behavior in the home, school, and community. Differing with Menlove, they found that those children who were older at the time of adoption tended to have more severe anti-social symptomatology.

The scope of the problem of possible increased sociopathic behavior in adopted children is quite large because there are many children at risk. Approximately one percent of the nation's present population is represented by EFA children, two-thirds of whom are adopted through social agencies. The majority of EFA children are born out-of-wedlock. If indeed, EFA children are more prone toward anti-social activity than IFA children, the contribution of poor prenatal care, obstetrical casualties and inadequate pediatric examination must be entertained.

From the point of view of child-rearing, one of the recurring themes for etiology of anti-social activity concerns the method in which the child is told about his adoption. In this regard, some comments from the pamphlet *Adoption of Children*¹⁶ are pertinent.

"Adopted children need to be told that they are adopted — because that is the truth of the matter. Experience in most agencies and child guidance clinics throughout the country has established that almost never does the child reach maturity without learning of his adoption. If the child does not hear of his adoption until a time of other crisis, the shock of learning that his parents were not truthful with him may prove greater than the shock of learning that he was adopted. What the child learns about adoption depends as much or more on how the parents consciously or unconsciously feel about having an adopted child as the content of what they tell the child. Most adoptive parents need help in telling their children about adoption, and the family pediatrician should be sensitive to this need.

"Personality development is to a large degree dependent on one's knowledge of his background. Interest in where one comes from seems to occur first at three or four years of age and it is then most appropriate to give the child some elementary information about the birth process. Children are probably not psychologically ready to receive the concept of their adoption at this age. When they are six or seven years old, however, personality development has progressed to the point where they can and should be told of their adoption. The timing and amount of information given, of course, must be individualized. Though individuals vary, there generally is renewed interest in and a need to discuss origins in early adolescence and again in late adolescence and/or during the pre-engagement period."

We accepted the findings that anti-social activity, as indeed, psychiatric vulnerability, periled EFA children out of proportion to their counterparts in biological children. We were interested in determining how these adopted children, as adolescents, regarded their status and viewed other adopted children. Could so many adopted adolescents remain at special risk for anti-social behavior because of any series of factors that were within the scope of child-rearing practice? Our clinical facility offered an unusual opportunity for such a study because it is evenly divided between those children who have come before the court as juveniles, and those who had no involvement with the court. We wondered whether there would be differences in the two groups based solely on the fact that one group (court) had been legally charged and brought to trial. The important differential between the two groups was the active involvement of adoptive parents as promulgators or signatories of complaints against their children (court group) which resulted in court-ordered

psychiatric examination versus adoptive parents who had voluntarily sought psychiatric examination without recourse to court involvement. We therefore confined ourselves to accumulating sufficient cases that could be matched within our clinic, with the sole variable remaining the passage through juvenile court.

Material and Method

Over a four-year period a pool of experimental subjects was selected according to the primary criteria of representing extra-familial adoptions (no biological relation) as referred to the Children's Mental Health Clinic of Bergen Pines Hospital. During this period the ratio of adopted children to non-adopted children by both court and community sources approximated 1:25. The 30 subjects selected from the total pool of nearly 100 adopted referrals over the four year period were divided into two groups matched for age at the time of referral, sex, age at the time of adoption, and general diagnostic category. The first group constituted community referrals with no known court involvement. The second group was selected from children who had appeared before the Court of Juvenile and Domestic Relations, and who had been required to undergo social investigation, psychological testing, and psychiatric examination as a condition of their probationary status. The offenses committed by these children ranged from the less serious (habitual runaway, truancy, incorrigibility) to the more serious (break and entry, larceny and variations of assault).

The Children's Mental Health Clinic of Bergen Pines Hospital is a part of a general county-sponsored hospital. It draws referrals from all parts of a county of nearly one million inhabitants in northern New Jersey. The constituency of the clinic population mirrors the community as largely middle class,¹⁷ suburban, with 10 percent non-Caucasian patients.

The two groups of matched subjects (community and court) were interviewed with a questionnaire (Figure 1) during their initial period of involvement in diagnosis within the clinic. Although more than 30 subjects had been given the questionnaire, the 30 subjects compared in this study were culled from the larger total for

Figure 1

Questionnaire Used in Interviewing Court-Referred and Non-Court-Referred Adopted Children

1. How old were you when you first learned you were adopted?
2. Who told you?
3. What did they say?
4. Did you read any stories about adoption? What were they?
5. Do you have adopted brothers or sisters?
6. Do you have brothers and sisters who are not adopted?
7. Do you know any other adopted children?
8. Did you ever have thoughts or daydreams about having other parents? If you imagined other parents, what were they like?
9. Do you know anything about where you were born or who your other parents were? (If yes, exactly what do you know? How did you learn?)
10. Have you run away from home? (If yes, what caused this? If no, have you thought of running away or threatened to?)
11. Has anyone teased you or ridiculed you about being adopted? (If yes, what did they say?)
12. Have your parents ever mentioned that you were adopted when they were angry with you?
13. Did you get homesick?
14. Did you ever have a blanket or special toy that you used to carry around with you?
15. Have you ever thought of adopting children when you are married? (If yes, what would you tell them about adoption and when?)
16. Finally, what's the first thing you can remember the farthest back?

matching as closely as possible in terms of population characteristics.

Results

Table 1 summarizes characteristics of the 30 selected adopted subjects with respect to age, sex, age at adoption and diagnostic findings. As shown in the table, the two experimental groups of adopted children compared are closely matched.

Table 1

Characteristics of Two Populations of Adolescent Adoptees

Characteristics	Court Referred	Community Referred
Average Age at Time of Adoption	14 months	9 months
Average Age at Time of Referral	14.4 years	13.7 years
Males	9	9
Females	6	6
Diagnostic Category:		
Transient Situational Disturbance	5	4
Behavior Disorders	5	6
Personality Disorders	2	2
Neurosis	1	1
Psychosis	1	1
Non-Psychotic Organic Brain Syndrome	1	1

Table 2

Summary of Positive Answers to Questionnaire Presented to Court Referred and Non-Court Referred Adopted Children

<i>Questionnaire Item</i>	<i>Court Referred Adopted Children: (n = 15)</i>	<i>Non-Court Referred Adopted Children: (n = 15)</i>	<i>Probability: (chi square)</i>
Homesickness Reported	11	1	p value < 0.05
Knowledge Reported of Birthplace and Circumstances on Birth	13	4	p value < 0.05
Actual Runaways	13	6	p value < 0.05
Parents Reportedly Mentioned Adoption in Anger or While Administering Discipline	9	4	p value < 0.10
Recall of Transitional Objects	6	11	p value < 0.10
Ridicule Regarding Adoption Reported	5	1	p value < 0.10
Presence of Non-Adopted Siblings at Home	10	6	
Fantasies of Biologic Parents	12	12	
Earliest Memories:			
Positive	7	6	
Negative	3	2	
With Biologic Parents	8 out of 10	5 out of 8	
Presence of Adopted Siblings at Home	8	11	
Thoughts of Adopting Children in Future	6	5	
Thoughts about Telling Possible Future Adopted Children	8	5	
Average Age when informed of Adoption	6.5 years	6.5 years	
Person Who Told of Their Adoption:			
Father	0	2	
Mother	6	8	
Both	5	3	
Neither	4	2	

Table 2 lists the results obtained from the questionnaire (Figure 1) given to these experimental groups. Results have been arranged in rank order of descending significance. Data presented in Table 2 represent the number of positive responses given to each question by subjects in the court-referred and the non-court-referred groups. The first three results on the table recording positive answers for homesickness, knowledge of circumstances surrounding birth and episodes of runaway in the court-referred subjects are considered highly significantly different (p value 0.05) from the answers of non-court-referred subjects. Two other results favoring court-referred subjects with significant probability (p value 0.10) are the mention of adoption in anger or during disciplinary action by the parents and the experience of actual ridicule about adoptive status. The result of significant probability (p value 0.10) favoring non-court subjects, was their reported use of transitional objects.

The remaining observations are attributed less significance in distinguishing the two groups. It can be observed, however, that court-referred children had both more natural-born siblings,

and more tendency to fantasize about biologic parents, usually ascribing positive feelings. With respect to their earliest memories, court-referred children also involved one or both of the fantasied biologic parents.

Discussion

This study produced a large yield of contrasting results between the two populations. We wondered what difference aside from mere court involvement was implied. The court-referred group was not necessarily more sociopathic, because the variable of diagnosis was controlled via the selection process. We were tapping another vein of difference, likely the degree of parental support.

The single most important finding, statistically, was the inordinate amount of homesickness reported by the court group. If their parents were more rejecting or less available, or ambiguous in their supply of security, the homesickness reported by this group would understandably be correlated with the finding of the majority — that parents had mentioned their adoptive status in anger. Homesickness is a complex feeling state, akin to "school phobia"

in its most intense forms, and often resembling marked ambivalence of attitude rather than longing for return.

We found the great majority of court-referred children to have had more knowledge of their birthplace and some details of the circumstances of their birth. Those children who were not court involved had substantially less knowledge. In fact, over twice as many of the court involved children had been running away from home. It has been our impression in interviewing adopted children who had run away, that the geographical location of the birthplace was the likely direction whether deliberate or unrealized. Our geographical location makes for runaways other than toward the East. It would be interesting for a mid-continental facility to study the direction of runaways by adoptees, particularly if they knew of their biological source of origin. Wellisch¹⁸ and later Sants¹⁹ had described what was termed "genealogical bewilderment" among adopted children. These children are described as in relentless pursuit of the facts of their origin. Sants urged that the child be told not only of his adoption, but also the facts of his origins, citing the principle that conscious acceptance of known facts tends to improve family relations. Later, the Committee on Adoption of the American Academy of Pediatrics had called for parents to discuss with the child aspects of his background. McWhinnie²⁰ found in her study that "adopted children prefer to learn details from their adoptive parents, and ideally work should be directed at helping the parents to resolve with their adolescent child curiosity and fears about natural origins."

We believe, rather, that it is prudent to withhold facts of biological origin. We have found several adolescent adoptees whose knowledge of biological origin including geographical locale and other details, was frankly detrimental to their welfare. We believe that children should generally be told of adoption, although, there are quite a number of instances where they are over-told. Parents who over-tell or explain the adoption process ritualistically — almost as a confession — are likely to weaken their ability to engender security and stability of identification. As an example of over-telling, Schnaper²¹

criticizes the telling of the "chosen one" story. He writes: "Not only does over-explaining reflect the parents' anxiety, but it serves to suppress the child's expression of anger toward the parent who must have the child's love. Also, the verbal barrage is intended to postpone, if not abolish, further questions." Schnaper sagely posits the inevitable question for the child: "If you chose me, who unchose me?"

In both court and non-court groups in our study, the average age when the child was told of his adoption was 6.5 years or in the first grade of school. We were not able to test the hypothesis of age of realizing adoption as a function of any of our questions.

In reviewing results drawn from our data, the high incidence of runaway that was found in both groups, with particular emphasis on such running away occurring during adolescence, suggests that some preventive measures might be implemented. It is our feeling that these runaways are largely the extended reaction to usual adolescent arguments with parents. If parents are not aware that they are being challenged for direct displays or expressions of security, the adopted child is more likely to carry through. If indeed, adoptive parents reply in anger or mention the adoptive status during family quarrels, their response can become a direct invitation to runaway. Nineteen of our thirty subjects ran away, and thirteen of those nineteen had experienced parents mentioning their adoptive status in anger. Several of the children interviewed during this study indicated that their running away was either part of their quest for biological identity or triggered by direct mention of their adoptive — and therefore inferential — second class family status.

Mention of a child's adoptive status in anger is one of the most damaging indictments that several of our subjects perceived. While answering the questionnaire several of the court-involved group were quite explicit about the incident, and examples of their words are quoted below:

Question — Have your parents ever mentioned that you were adopted when they were angry with you?

Example #1 — "Yeah . . . and my mother would say it wasn't her idea to take both of us, it was my father's idea . . .

sometimes she told me that if I didn't stop misbehaving she would send me back . . ."

Example #2 — "Oh, I heard that one a lot . . . she (mother) used to say it as a punishment . . ."

Example #3 — "Sure . . . my mother would say she took me out of an orphanage and I wouldn't be anywhere if it weren't for her, and that my mother was probably a tramp . . . you know, Doctor, that's all I had to hear . . . can you imagine a mother saying anything like that?"

The above examples were drawn from the court-involved group. Of the non-court group, no children who responded that their parents had spoken of their adoptive status in anger chose to illustrate the incident with direct quotes or emphasized examples. It remains to be said, that some adopted children "throw up" their adoptive status to parents in anger, and although this possibility was not asked for in our study, two children mentioned their own role in this, one of them stating: "No, my parents never said that to me, but when I get angry with them, I say they're not my real parents!"

Adoptive parents tend to view their children's symptomatology as either the result of their errant child-rearing practices, or of the child's basically faulty endowment. It is less often that adoptive parents are able to accommodate to the notion of interplay between nature and nurture. Adopting parents thus are prone to denial or overwhelming self-doubt or guilt. Neither attitude is healthy for the parent, and both attitudes perpetuate and aggravate the child's difficulties. Counseling of parents of troubled adopted children should investigate possible unrealistic adherence to either presumed total responsibility, or denial for contribution to the child's difficulties. Parents should therefore be counseled about their need to establish firm guidelines for adopted adolescents, and to relate to them not as special children, but rather as biological parents would ordinarily relate.

In this study, and in our experience in treating adopted adolescents generally, we have not heard complaints about the sudden exacerbation of problems or traumatic consequence of children learning about their adoption from non-family members. Therefore, some of the higher risk for adoptees' vulnerability to learning problems or sociopathic behavior may reflect inadequate pre-natal care or complications during

the pregnancy. The over-representation of behavioral problems in adoptees is more likely the response of the child to weakened family cohesion, problems in discipline and guidance, and the adoptee's perception of less accountability for actions because of altered family status.

Summary

In summary, we conducted a study via questionnaire interview of matched adoptive adolescent subjects who were distinguished only by parent-initiated court involvement versus parent-initiated psychiatric referral. Both groups presented high occurrence of runaway, and in the court group, higher incidence of runaway was positively correlated with information that the child had been told of the biological origin. Other findings included the very high incidence of homesickness in the court group, correlated again with their experience of either ridicule of the adoptive status or parental mention of adoption during episodes of anger. An incidental finding of high retention of transitional objects was found in the non-court group, and remains not well understood in terms of the grouping of the children studied. Extrapolating from our study of disturbed adolescent adoptees, we conclude that it may not be prudent to tell adoptive children facts of their biological origin, and suggest that the high incidence of runaway in disturbed adopted adolescents reflects impairment in their perceived basic security. This perception of security within the family can be further weakened by parental mention of the adoptive status in anger. Treatment of the running away adopted adolescent is felt to require active investigation and amelioration of basic family cohesion characteristics.

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Bergen Pines County Hospital

Ophthalmology — Peter P. Walles, M.D.

One common problem seen in the office is a patient presenting with an inflamed eye. Acute conjunctivitis is the most common cause. Other disease entities that often present with an inflamed eye are acute glaucoma, acute iritis, corneal trauma, or infection. The above conditions, if not recognized promptly, can lead to major

ocular morbidity with sight threatening consequences.

A useful reference chart can aid in the differential diagnosis of the less serious conditions versus the sight threatening.

<i>Signs and Symptoms</i>	<i>Acute Conjunctivitis</i>	<i>Acute Iritis</i>	<i>Acute Glaucoma</i>	<i>Corneal Trauma or Infection</i>
Incidence	extremely common	common	uncommon	common
Discharge	moderate to copious	none	none	watery or purulent
Vision	no effect	slightly blurred	marked blurring	usually blurred
Pain	none	moderate	severe	severe
Cornea	clear	usually clear	steamy	may be foreign body, abrasion, or other
Conjunctiva Injection	diffuse	primary circum corneal	diffuse	diffuse
Pupil Size	normal	small	large	normal
Pupillary light response	normal	poor	poor or none	normal
Intraocular pressure	normal	normal	elevated	normal

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*From "The Cooper Review" published by Cooper Medical Center, Camden, where Dr. Walles is assistant ophthalmologist.

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CASE REPORTS

A case of leiomyosarcoma of the skin on the medial aspect of the leg below the knee is presented. This case may have arisen from the smooth muscle of blood vessels. Only four cases of leiomyosarcoma of the legs were found in the literature and we present this additional one.

Leiomyosarcoma of the Leg*

René Joyeuse, M.D., N. D. Pontilena, M.D., Kenneth Kappy, M.D., and C. C. Gumucio, M.D./Newark

Leiomyosarcoma of the superficial soft tissue is a very rare lesion. Stout¹ reported only 35 cases up to 1956 and though most were located on the lower extremity, only three of the entire series were present on the leg. Phelan, *et al.*,² added 10 cases to the literature in 1962 but none of these was reported as arising on the leg. Haim³ reported two more in 1970 with one located on the shin.

Case Report

This is a case of leiomyosarcoma of the left leg in a 65-year-old man, who presented with a chief complaint of "shortness of breath" on exertion. A diagnosis of congestive heart failure and chronic obstructive lung disease was made and the patient was treated accordingly.

On physical examination, a 2 x 1 cm. red, firm, freely movable mass was found on the medial aspect of the left leg below the knee. The patient claimed that he first noticed the mass five years earlier and that it gradually increased in size. Aside from being "itchy," it produced no other symptoms and never ulcerated. There was no inguinal adenopathy. The



Figure 1 — Lower magnification of skin lesion. There is focal acanthosis. The upper and lower corium are diffusely infiltrated by neoplastic cells arranged in interlacing bundles. The tumor is not encapsulated.

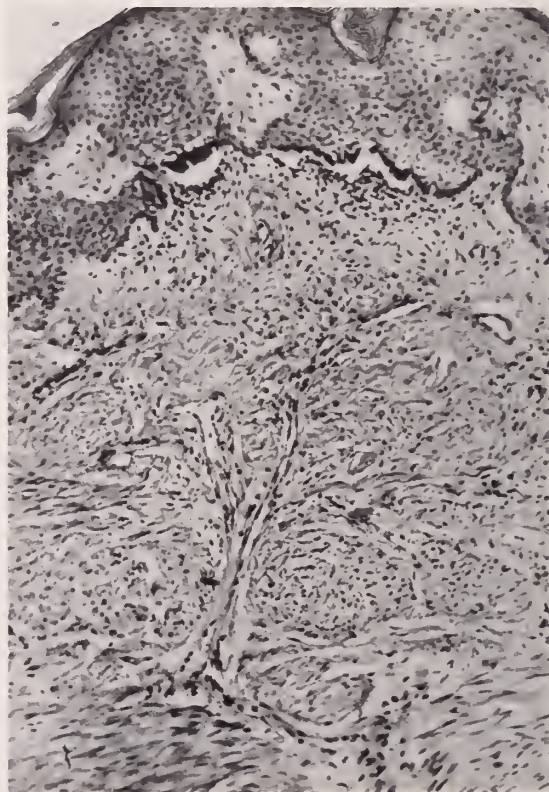


Figure 2 — Higher magnification of central area shows flattened blood vessels whose musculature merges with the surrounding tumor cells.

lesion was diagnosed clinically as squamous cell carcinoma. X-ray of the leg did not show bone involvement and chest x-ray did not reveal hilar adenopathy.

Excision of the lesion revealed a 2.5 x 2.0 cm. brown mass which on sectioning appeared firm, opaque, and grey-white. Microscopically, it occupied the dermis and extended into the subcutaneous fat. It was composed of spindle cells with mitotic figures, growing in matted bundles (Figure 1). The le-

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sion was not encapsulated and the presence of smooth muscle cells was proved by Trichrome stain. The neoplastic cells seemed to merge with the musculature of the surrounding blood vessels (Figures 2 and 3). A diagnosis of leiomyosarcoma of the skin possibly arising from the underlying blood vessels was made.

A wide excision (11 X 6 cm.) was then performed and the defect was covered by a skin graft. No residual tumor was seen on sectioning of the surgically removed tissue. The graft took well and the patient was discharged from the hospital. On examination seven months later, there was no local recurrence, the inguinal lymph nodes were not palpable and the chest x-ray did not reveal hilar adenopathy.

Discussion

Leiomyosarcoma of the superficial tissues may arise from the arrector pili muscles, from smooth muscles of blood vessels, or from sheets of smooth muscle, for example, the dartos.⁴ They appear to be more common in females than in males and occur with greater frequency between 40 and 60 years of age. They average 5 cm. in diameter and are seldom encapsulated. The pathology is appropriately described by Stout.¹ These lesions tend to metastasize to the lungs via the blood stream and to regional lymphatics and lymph nodes. Treatment is wide surgical excision to prevent local recurrence and metastatic spread. Excision of the lesion in our case, after very careful microscopic study of numerous sections, was found to be adequate for borders and in depth. Simple enucleation is inadequate because of the irregular outgrowth of cancerous cells from the main body of tumor.

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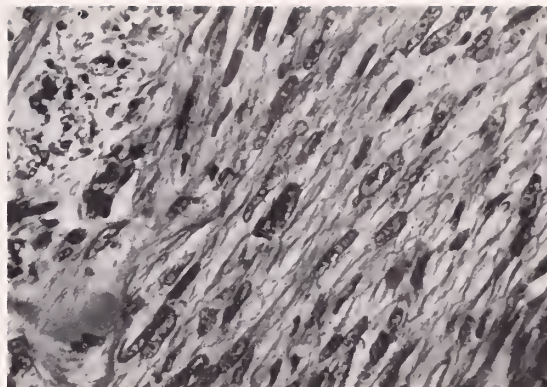


Figure 3 — Higher magnification of focal area of tumor. Giant malignant cells are present. Few intracytoplasmic longitudinal myofibrils are noted. The nuclei are pleomorphic, hyperpigmented, elongated and blunt ended. Intracytoplasmic vacuoles are present. Scant intercellular substance can be seen.

Phelan² does not believe prophylactic lymph node dissection is warranted.

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Incidence of biliary tract disease in those 21 years and younger has been 1 to 5 percent. Etiology varies with age, being congenital in the newborn (two-day old infant being the youngest), infectious in young children, and gallstones in adolescence; CBD stones are quite rare. Thorough H and P, stool cultures, agglutination testing, and RBC morphology/fragility studies are imperative even though 20 percent of patients have no definite etiology. Right paramedian approach gives excellent exposure for exploration in cases where the diagnosis of appendicitis is in doubt. Post-cholecystectomy complications are low.

Cholecystitis and Cholelithiasis in Childhood and Adolescence: Two Case Reports

Rade Pejic, M.D./Camden*

The objective of this communication is to stress the fact that biliary tract disease is not too infrequent in adolescence, even though it is less common in childhood. It should be thought of in any patient who may present with right-sided abdominal pain from first two weeks to the tenth decade of life. The incidence of cholecystitis and cholelithiasis has been reported to be from less than 1 to 5 percent in patients below 21 years of age.¹ A brief review of the history, pathophysiology, diagnosis, and treatment and two case presentations will illustrate the subject.

Acute cholecystitis in childhood was originally reported by Gibson in 1722. His patient was a 12-year-old boy who died of peritonitis secondary to perforation of the gallbladder; an impacted cystic duct stone resulted in obstruction, empyema formation, and subsequent rupture.^{2, 3} Ulin reported the youngest patient in the literature: a 2-day-old infant who was treated by cholecystectomy for cholelithiasis.⁴

Case Reports

A 13-year-old female was admitted to Boston Naval Hospital because of nausea and right lower quadrant pains of one-day duration. The patient denied chills, fever, diarrhea, or constipation but did recall that on one occasion ice cream precipitated right-sided abdominal pain which subsided spontaneously. The physical examination was entirely within normal limits except for a temperature of 99.8° F and abdominal findings. The patient noted tenderness to palpation lateral to the umbilicus on the right and bowel sounds were decreased. There was no true guarding or rebound and the rectal examination was normal. X-rays of the chest and abdomen were normal. The white blood count was 10,500 with 82 PMN's, 5 bands, 10 lymphs, 2 monos and 1 eosinophile.

The clinical impression was a high-lying retrocecal appendix and the patient was prepared for surgery. The appendix was entirely normal but further exploration revealed an acutely inflamed gallbladder. By extending the original paramedian incision superiorly, good exposure was obtained and a cholecystectomy and incidental appendectomy were performed. The patient had an uneventful postoperative course.

The gallbladder contained five large-faceted stones and clear viscid bile, the culture of which was sterile. The cystic duct appeared normal and gallstone analysis revealed them to be composed of a cholesterol, calcium carbonate and calcium bilirubinate mixture. Complete hematological evaluation revealed normal red blood cell morphology and fragility testing.

The patient's mother, father, 8-year-old and 17-year-old sisters were studied by oral cholecystography. The older sister was found to have asymptomatic cholelithiasis but normal hematologic and agglutination studies. She had elective surgery at which the gallbladder was found to be filled with multiple 1 to 1.5 cm. faceted gallstones. The anatomy of the cystic duct was normal. The patient underwent an uneventful cholecystectomy and appendectomy and had a normal postoperative course. Bile analysis was normal and the stones were of the same composition as her sister's.

In summary, these two young females with idiopathic cholelithiasis are typical of 20 percent of the patients in this age group, with this disease.

Discussion

Pathogenesis — Bonta, *et al.*,⁵ listed the pathogenesis of gallbladder disease by age groups as follows:

- (a) Neonatal period and infancy: Congenital deformities of the biliary tract
- (b) Early childhood: Infectious

*This report is based on two cases seen by the author while he was assistant chief of surgery at the Boston Naval Hospital. Dr. Pejic is currently on the general surgical staff at the Cooper Medical Center, Camden, and attending in surgery at the Garden State Memorial Hospital, Marlton.

(c) Late adolescence and adulthood: Intimately associated with and frequently due to cholelithiasis

In the first group, the possible factors that may be responsible for cystic duct obstruction with subsequent gallbladder distention and inflammation are: congenital cystic duct valves, a long narrow and tortuous cystic duct, aberrant vessels producing extrinsic compression of cystic duct, congenital bands and a choledochal cyst.

In early childhood, acute systemic infectious diseases are frequently associated with cholecystitis. Barton, *et al.*,⁶ reported a case of a 26-month-old girl with acalculous cholecystitis secondary to leptospirosis. Among other causes, Potter has listed typhoid, influenza, diphtheria, appendicitis, scarlet fever and infections of the digestive tract as precursors of cholecystitis.⁷ Hasson's case report in 1835 of acute non-calculous cholecystitis in a child, associated with typhoid fever and confirmed by autopsy, is the first report of such an entity as quoted by Potter.⁷ In 1922, however, Houze was the first to treat successfully a five-year-old child with acute non-calculous gangrenous cholecystitis by cholecystectomy.⁷

Cholecystitis has also been associated with hemolytic streptococcal septicemia, acute glomerulonephritis, erysipelas and salmonella oranienburg.⁶ The pathogenesis of acute cholecystitis in this group may very well be due to bile stasis secondary to dehydration from inadequate fluid intake, administration of drugs to relieve pain and decreased hormonal stimulation of the gallbladder.⁹ Cholelithiasis is frequently associated with cholecystitis in the third group. However, common bile duct stones are much less frequent than in the patient population above twenty one years of age.¹⁰

Hemolysis by the spleen secondary to red blood cell abnormalities, such as hereditary spherocytosis, hereditary elliptocytosis, thalassemia, sickle cell disease, hereditary non-spherocytic anemias and glucose-6 phosphate dehydrogenase deficiency is responsible for alteration in the bile salt-cholesterol-lecithin ratio¹⁰ and subsequent gallstone formation. In addition,

pregnancy, with resultant bile stasis in the teen patient has been associated with greater incidence of cholelithiasis and cholecystitis.¹

Because of the atypical pathophysiology of cholecystitis and cholelithiasis in the young patient, the physician should include the following laboratory tests as part of his work up: agglutination testing for salmonella typhi and paratyphi, cold agglutinins, red blood cell morphology, and fragility testing.⁹

Diagnosis — The greatest diagnostic difficulty in childhood is the failure to consider this disease in young patients who present with abdominal pain.¹² Gastrointestinal disturbance, nausea, vomiting and constipation are frequently associated with cholecystitis in childhood and adolescence. However, these are non-specific symptoms; furthermore, the abdominal pain may have a vague localization.

Diarrhea and colic may be present but a history of indigestion, flatulence, and food intolerance is seldom obtainable. Fever and leukocytosis are common signs. At times, localized rigidity, spasm, tenderness, and even a palpable mass may be present. However, the location and nature of the tenderness is responsible for the common initial diagnosis of a high lying appendicitis as seen in the first case.

If time and symptoms permit, cholecystography and duodenal drainage for examination for cholesterol crystals, may be done. Sick cell crisis with abdominal pain may be impossible to distinguish clinically from biliary colic; therefore, patients with sickle cell disease and abdominal cramps should have cholecystography. Other entities which should be considered in young patients presenting with right-sided pain are: infectious hepatitis, intestinal obstruction, regional enteritis, cecal diverticulitis, right lower lobe pneumonia, renal disease, pancreatitis, pericarditis, perforated viscus, porphyria, mesenteric adenitis and Meckel's diverticulitis.

When operating on an adolescent with right lower quadrant pain, especially a young female, it may be prudent to make a small paramedian incision in the right lower quadrant. The appen-

dix can be removed very easily via this approach, but more importantly, if the appendix is normal, excellent exposure may be obtained for exploring the abdominal cavity by extending the incision superiorly to examine the gallbladder or inferiorly to examine the ovaries, small bowel, and so on. If cholecystitis should be found, a cholecystectomy may safely be performed through this incision. Exploration of the common bile duct is rarely indicated since common bile duct stones are usually not found in childhood. Consequently, the mortality and morbidity in adolescents undergoing cholecystectomy is low. The exact etiology is usually obscure in this type of a patient.¹³

The major differences between gallbladder disease in childhood vs. adolescents or adults are:

- (a) Acute cholecystitis in childhood is usually associated with acute systemic disease.
- (b) Cholelithiasis and particularly choledocholithiasis is infrequent. Also, jaundice is not a great indication for exploration of the common bile duct.
- (c) Twenty-five to forty-five percent of children with acalculous cholecystitis have jaundice secondary to inflammation around the common bile duct.² Cystic duct obstruction may be due to an inflamed cystic node or periportal edema and infection.
- (d) If stones are found, they are usually pigmented.
- (e) Chronic dyspepsia is not common.
- (f) In childhood there is a male preponderance, whereas in adolescence there is a female preponderance.
- (g) Bacterial identification is more frequent.
- (h) Associated malignancy is much less frequent.

Summary

This presentation will familiarize the reader with several factors regarding cholecystitis in the young patient. It is hoped that the primary physicians as well as the surgeons will consider this diagnosis more often and proceed in an orderly fashion to evaluate patients as suggested. Important points to remember are:

- (a) Any adolescent presenting with an acute abdomen should have a differential diagnosis based on the history and physical findings. If cholecystitis is suggested, it should be properly worked up and evaluated.

- (b) Even though the cause is undetermined in 20 percent of patients cholecystitis varies with the age group, i.e.: newborn — congenital, young child — infectious, older children — stones.

- (c) Stool cultures, agglutination and red blood cell fragility testing should be performed in all adolescent patients.

- (d) In childhood, males are more common, but in adolescence females outnumber the males.

- (e) The best "incision of indecision" in young females is a right paramedian approach.

- (f) In adolescence stones are found frequently but in early childhood, they are found rarely. Common bile duct stones are rare in both groups.

- (g) Postoperative morbidity and mortality in adolescence and childhood is low.

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A patient with rheumatic heart disease, predominant mitral incompetence and, probably, mitral stenosis, pulmonary hypertension, congestive heart failure, and massive dilation of left pulmonary artery displayed hoarseness owing to left recurrent laryngeal nerve palsy (Ortner's syndrome) and tracheal tug (Oliver's sign). Ortner's syndrome is an infrequent complication of mitral valve disease. Pulmonary artery dilatation has not been previously reported to cause tracheal tug.

Mitral Valve Disease Associated with Tracheal Tug and Ortner's Syndrome

**N.V. Karhade, M.D. and
R.B. Bhagwat, M.D./Chicago***

Hoarseness in cases of mitral stenosis owing to left recurrent laryngeal nerve palsy was first described by Ortner in 1897. It is an uncommon symptom of mitral heart disease that has also been cited by various authors.¹⁻¹⁰ Tracheal tug (Oliver's sign) has *not* been reported as a manifestation of mitral valve disease. This article describes a patient with predominant mitral incompetence and probably mitral stenosis, pulmonary hypertension and congestive cardiac failure who had both Ortner's syndrome and tracheal tug.

Case Report

A 37-year-old male was admitted to Medical College Hospital because of exertional dyspnea of two years' duration and progressive hoarseness of six months' duration. He gave a history of rheumatic fever twenty years previously. There was no history of syphilis, gonorrhea, hemoptysis, dysphagia, fever, chest pain, or loss of appetite. Physical examination revealed a thinly built patient. The pulse was 108/min., regular and low in volume. Blood pressure was 96/70. Peripheral pulses were equal and neither clubbing nor cyanosis was observed. Jugular venous pressure was raised 7 cms. above the clavicle. A trace of edema was present. The liver was enlarged three fingers-breadth below the costal margin; it was tender but not pulsatile. Rales were heard at both lung bases. The precordium was bulging and the apical impulse was felt in the 6th intercostal space at the anterior axillary line. It was heaving in character and associated with a systolic thrill. A moderate parasternal heave was present and a pulmonic shock was felt in the second left interspace. A grade 5/6 pansystolic murmur which was heard over the mitral area, was conducted to the axilla. There was a short 2/6 apical diastolic murmur with presystolic accentuation; the third heart sound could not be heard. P₂ was loud, sharp, and split and the second sound widened during inspiration. A distinct tracheal tug was felt.

The erythrocyte sedimentation rate, blood count and urine analysis were normal. The VDRL was non-reactive. The

electrocardiogram (Figure 1) showed right axis deviation and clockwise rotation. A chest X-ray (Figure 2) showed cardiomegaly, prominent pulmonary conus, left ventricular hypertrophy and left atrial enlargement. The aorta appeared normal. A barium swallow (x-ray study) showed some left atrial enlargement. (Figure 3) Indirect laryngoscopy demonstrated left vocal cord paralysis. The clinical diagnosis was rheumatic heart disease with predominant mitral incompetence, probable mitral stenosis, pulmonary hypertension, congestive heart failure and Ortner's syndrome.

Comment

The left recurrent laryngeal nerve hooks around the ligamentum arteriosum and passes behind the aorta to the left side of the trachea and esophagus.¹¹

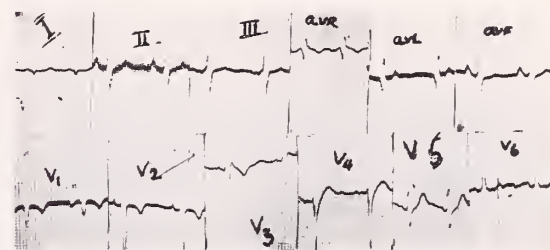


Figure 1 — Electrocardiogram showing right axis deviation.

Ortner theorized that the enlarged left atrium is responsible for compression-paralysis of the recurrent laryngeal nerve.¹ In our case there was evidence of left atrial enlargement. However, the pulmonary artery was markedly enlarged. Several authors now think that an enlarged pulmonary artery may be responsible for com-

*When this case report was presented Dr. Karhade was associated with Bergen Pines County Hospital in Paramus. He is currently in residency at Cook County Hospital in Chicago. Dr. Bhagwat is now Professor of Medicine, Medical College Aurangabad, Maharashtra State, India, where Dr. Karhade was formerly associated.



Figure 2 — PA chest x-ray showing cardiomegaly, very large pulmonary conus and left pulmonary artery and left ventricular hypertrophy. Aorta is normal.



Figure 3 — Barium esophagogram is right anterior oblique position. There is some left atrial enlargement.

pression paralysis.^{1, 3, 4, 8, 9} Ari, *et al.*,⁸ thought that the voice might improve after surgery for mitral valve disease. The relative infrequency of left recurrent nerve palsy when compared to the common occurrence of pulmonary artery dilation, indicates that some other factors such as mediastinitis, lymphadenitis, pericarditis, may contribute.^{1, 9}

An important feature of our case was the presence of a tracheal tug. The tracheal tug is caused by a downward pull exerted by the aortic arch on the left main bronchus which is transmitted to the trachea and cricoid. The other recognized causes of tracheal tug, which include aneurysm of the aorta, dilatation of the aorta owing to aortic insufficiency, mediastinal tumors, pulsating sarcoma of the mediastinum and retraction of the upper lobe of the left lung, were all absent in our patient.^{1, 3, 12, 13} However, a markedly enlarged left pulmonary artery could behave in the same way as an aneurysm of the aorta and transmit pulsations to the left bronchus trachea and cricoid. The left atrium being inferior and posterior to left bronchus is unlikely to transmit pulsations to cricoid or have a pull effect. In our experience a patient with idiopathic dilatation of left pulmonary artery had a tracheal tug.¹⁴

Therefore, because of the absence of all other recognized causes of tracheal tug in our patient, and the finding of a large pulmonary conus and left pulmonary artery, we believe that the pulmonary artery pulsations were transmitted to the cricoid cartilage and appreciated as a tracheal tug.

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Criteria Evaluation of Emergency Room Medical Care

New Jersey Committee on Trauma

American College of Surgeons

William A. Dwyer, Jr., M.D., Chairman

Approximately twenty years ago, the New Jersey Committee on Trauma of the American College of Surgeons conceived the idea of surveying the hospital emergency rooms in our state. These evaluations, which were conducted by surgeons knowledgeable in the field of emergency care, had two purposes. The first was to acquaint the hospital administrators and emergency room personnel with the Trauma Committee's concept of an adequate emergency care area. This was done through the use of a pre-set form utilized by the surveyors to determine what personnel, policies, procedures and equipment were in place in the various emergency rooms. The second purpose was to provide an opportunity for each hospital staff to discuss the findings in its hospital with the surveyors in a discussion period that followed the completion of the study. At that time, this technique did serve as a very useful educational tool, which has since been adopted by several other states with similar results.

About six years ago, a number of members of the Committee became curious about the ongoing impact of what had originally been accomplished. There was an increasing discussion of the need for a statewide plan for emergency medical care for which a large amount of data would be needed. This reawakened interest coincided with the ability of the State Health Department, through its Emergency Medical Services Division, to fund a statewide, though modest, emergency room survey. Thus, the project was reinitiated.

Several Committee members developed a very comprehensive three-part form in order to gather as much information from the individual emergency room survey as possible. A modified version of this form, which is now employed by one of the hospital accrediting agencies, is so arranged that data can be transferred from it to a computer for analysis. Through additional

funds from the Regional Medical Program via the Interagency Commission for Emergency Medical Care, this analysis has been carried out.

Data Collection and Methods

Through the cooperation of the New Jersey Hospital Association, all of the hospitals in the state were requested by letter to voluntarily participate in the survey. The Committee on Trauma agreed in advance that any data released would hold confidential the names of individual hospitals.

Of the 102 hospitals thus contacted, (the State of New Jersey has constructed four additional hospitals since the start of the survey), five declined to take part. An additional five did not operate an emergency room of any kind. Of the remaining 92, 86 were reviewed by teams from the committee. Because of the length of time involved in completion of this examination, some rechecking, by letter or phone call, of the accuracy of the data obtained was necessary during this past year in order to ensure that the results were as correct as possible.

The investigation was terminated in 1973. One hospital studied has since closed its emergency room. Finally, three hospitals had to be excluded from consideration as to adequacy of specialized care because the data obtained were not sufficient for computer analysis. In all three instances, however, the surveyor's opinion and the data available show that the institution met the Committee's mandatory criteria.

Although the surveys were conducted by members of the committee, a preliminary form was sent to the hospital administrator for completion prior to the arrival of the committee team. This form consisted of detailed questions regarding planning of emergency services, staffing patterns for physician and nurse coverage,

type of facilities, equipment and ancillary services available, maintenance of written policy and procedure manuals and reference materials, and types of records kept. A Committee member also filled out a form, based on these standards, as part of the survey. After the physical evaluation, the committee members discussed the preliminary form with the hospital group and both forms were sent to the subcommittee chairman for comment and categorization.

It should be noted that the Committee on Trauma utilized the current standards of the Joint Commission on Accreditation of Hospitals in developing its questionnaire.

The Committee then set down minimal elements that it felt all emergency rooms should possess, and additional elements for the care of various specialized traumatic and disease states. (Tables 1 through 7)

Table 1
Mandatory Criteria

1. Emergency department must provide comprehensive 24 hour emergency service.
2. There must be licensed/experienced physician coverage at all times in the emergency department.
3. There must be 24 hour nursing coverage 7 days a week in the emergency room.
4. (a) A "medically trained person" must see all persons present in the emergency room.
(b) All persons must be examined by a licensed physician in a reasonable time.
(c) Discharge from the emergency room or admission to the hospital must be by qualified physicians.
5. All emergency room staff must be familiar with equipment and procedures.
6. Emergency room records must be kept on every patient.

Table 2
Criteria for Adequate Care of Coronary Emergencies

1. All of the Mandatory Criteria must be met.
2. Anesthesia and internal medicine specialists must be available at all hours on short notice (15 minutes or less).
3. (a) Emergency personnel get special training in cardiopulmonary resuscitation (CPR).
(b) Emergency personnel are familiar with all equipment, its location, and the procedure in using the equipment for various types of patients.
(c) Emergency personnel possess the knowledge and ability to provide immediate care for convulsions, obstructed airways, cardiac arrest, coronary occlusion and pulmonary embolus.

4. The necessary equipment for care of a coronary emergency is available in emergency room.
 - (a) Oxygen
 - (b) Ventilation equipment
 - (c) Suction equipment
 - (d) Endotracheal intubation equipment
 - (e) Defibrillator
 - (f) Parenteral fluids and infusion equipment
 - (g) Central venous catheterization tray
 - (h) Stretchers capable of positioning in Fowler's position
 - (i) Electrocardioscope
5. Procedure
 - (a) Physician attendance of patient at frequent intervals
 - (b) Constant nurse supervision and care
 - (c) Patients transferred to special care area early in their clinical course

Table 3
Criteria for Adequate Care of Chest Trauma

1. All of the Mandatory Criteria must be met.
2. Anesthesia, general, orthopedic, and thoracic surgery, and radiology consultative backup services must be available at all hours on short notice (15 minutes or less).
3. (a) Emergency personnel get special training in CPR technic.
(b) Emergency personnel are familiar with all equipment, its location, and the procedure in using the equipment for various types of patients.
(c) Emergency personnel possess the knowledge and ability to provide immediate care for severe hemorrhage, obstructed airways, multiple severe fractures, internal injuries.
4. Necessary equipment for care of chest trauma.
 - (a) Oxygen
 - (b) Ventilation equipment
 - (c) Suction equipment
 - (d) Endotracheal intubation equipment
 - (e) Thoracotomy tray
 - (f) Cut-down tray
 - (g) Central venous catheter tray
 - (h) Pleural drainage tray
 - (i) Surgical supplies for hemostasis and wound repair
 - (j) Parenteral fluids and infusion equipment including dextran and/or albumin and blood administration sets.
 - (k) Nasogastric tube set
 - (l) Standard emergency drugs
 - (m) Stretchers capable of positioning in Trendelenberg position
 - (n) Electrocardioscope
 - (o) Operating room available 24 hours a day with staff available on short notice (15-30 minutes or less) at all hours.
 - (p) All equipment must be kept in working order and be in assembled condition ready for immediate use; have adapters for use with adults, children, and infants.
5. (a) All persons must be seen promptly after admission by a medically trained person and by a licensed physician in a reasonable length of time.
(b) If the hospital is notified in advance of a patient's arrival, appropriate equipment and supplies are prepared for the patient's care.

- (c) Treatment is given to patients on a medical priority basis.
- (d) Emergency room personnel are prepared to render prompt care to the critically ill or injured upon reception at the hospital.
- (e) Operations requiring general or major regional anesthesia are *never* performed in the emergency service.
- (f) Critically ill patients are transferred to a special treatment center in the hospital early in their clinical course.
- (g) When necessary, patients are escorted for laboratory and/or radiological procedures.

Table 4

Criteria for Care of Multiple System Injuries

1. All mandatory criteria must be met.
2. Anesthesia, general, orthopedic, and thoracic surgery and neurosurgery consultative back up must be available at all hours on short notice (15 minutes or less).
3. (a) Emergency personnel get special training in CPR technic.
- (b) Emergency personnel are familiar with all equipment for various types of patients.
- (c) Emergency personnel possess the knowledge and ability to provide immediate care for severe hemorrhage, obstructed airways, multiple severe fractures, internal injuries.
4. Necessary equipment for care of chest trauma.
 - (a) Oxygen
 - (b) Ventilation equipment
 - (c) Suction equipment
 - (d) Endotracheal intubation equipment
 - (e) Thoracotomy tray
 - (f) Cut down tray
 - (g) Central venous catheter tray
 - (h) Pleural drainage tray
 - (i) Surgical supplies for hemostasis and wound repair
 - (j) Parenteral fluids and infusion equipment including dextran and/or albumin and blood administration sets
 - (k) Nasogastric tube set
 - (l) Standard emergency drugs
 - (m) Stretchers capable of positioning in Trendelenberg position
 - (n) Electrocardioscope
 - (o) Operating room available 24 hours a day with staff available on short notice (15-30 minutes or less) at all hours.
 - (p) All equipment must be kept in working order and be in assembled condition ready for immediate use; have adapters for use with adults, children, and infants.
5. (a) All persons must be seen promptly after admission by a medically trained person and by a licensed physician in a reasonable length of time.
- (b) If the hospital is notified in advance of a patient's arrival, appropriate equipment and supplies are prepared for the patient's care.
- (c) Treatment is given to patients on a medical priority basis.
- (d) Emergency room personnel are prepared to render prompt care to the critically ill or injured upon reception at the hospital.
- (e) Operations requiring general or major regional anesthesia are *never* performed in the emergency service.
- (f) Critically ill patients are transferred to a special treatment center in the hospital early in their clinical course.
- (g) When necessary, patients are escorted for laboratory and/or radiological procedures.

Table 5

Criteria for Care of Abdominal Injury

1. All mandatory criteria must be met.
2. Anesthesia and general surgical consultative backup must be available at all hours on short notice (15 minutes or less).
3. (a) Emergency personnel get special training in CPR technic.
- (b) Emergency personnel are familiar with all equipment, its location, and the procedure in using the equipment for various types of patients.
- (c) Emergency personnel possess the knowledge and ability to provide immediate care for severe hemorrhage, obstructed airways, multiple severe fractures, internal injuries.
4. Necessary equipment for care of abdominal trauma.
 - (a) Oxygen
 - (b) Ventilation equipment
 - (c) Suction equipment
 - (d) Endotracheal intubation equipment
 - (e) Cut-down tray
 - (f) Central venous catheter tray
 - (g) Surgical supplies for hemostasis and wound repair
 - (h) Parenteral fluids and infusion equipment including dextran and/or albumin and blood administration sets
 - (i) Nasogastric tube set
 - (j) Standard emergency drugs
 - (k) Stretchers capable of positioning in Trendelenberg position
 - (l) Operating room available 24 hours a day with staff available on short notice (15-30 minutes or less) at all hours.
 - (m) All equipment must be kept in working order and be in assembled condition ready for immediate use; have adapters for use with adults, children, and infants.
5. (a) All persons must be seen promptly after admission by a medically trained person and by a licensed physician in a reasonable length of time.
- (b) If the hospital is notified in advance of a patient's arrival, appropriate equipment and supplies are prepared for the patient's care.
- (c) Treatment is given to patients on a medical priority basis.
- (d) Emergency room personnel are prepared to render prompt care to the critically ill or injured upon reception at the hospital.
- (e) Operations requiring general or major regional anesthesia are *never* performed in the emergency service.
- (f) Critically ill patients are transferred to a special treatment center in the hospital early in their clinical course.
- (g) When necessary, patients are escorted for laboratory and/or radiological procedures.

Table 6
Criteria for Adequate Care of Poisoning by Ingestion

1. All mandatory criteria must be met.
2. Recent toxicology reference material and antidote information is kept readily available together with prominently displayed charts relating to the initial treatment of burns and cardiopulmonary resuscitation.
3. A clinical laboratory is available for use with emergency room patients twenty-four hours a day.
4. Necessary equipment for care of poisoning victims:
 - (a) Oxygen
 - (b) Ventilation equipment
 - (c) Suction equipment
 - (d) Gastric lavage tray
 - (e) Parenteral fluids and infusion equipment
 - (f) Standard emergency drugs
 - (g) Electrocardioscope
5. Patients are seen at frequent intervals by the physician and are constantly supervised by a nurse.

Table 7
Criteria for Adequate Care of Fractures

1. All mandatory criteria must be met.
2. Orthopedic and radiologic consultative backup must be available on call 24 hours a day.
3. If nurses are not in emergency room at all hours, there must be adequate provision made to summon them from other areas of the hospital.
4. Necessary equipment for care of fractures.
 - (a) Cut-down tray
 - (b) Surgical supplies for hemostasis and wound repair
 - (c) Splints and slings

There are many that will take issue with some or all of the data elements selected. The Committee itself recognizes that there are certain elements included that are somewhat idealistic, particularly as regards consultative backup and the availability of certain ancillary facilities and equipment. For example, an additional category regarding upper respiratory infection was developed. Whereas 72 facilities met the mandatory criteria and obviously would be able to handle simple colds, only 51 could pass as suitable for treatment of upper respiratory infections because of the inclusion of a need for consultative backup by a pediatrician and laboratory and x-ray facilities. Since this bordered on the ludicrous, the category was dropped from the study. The Committee utilized the American Medical Association system of categorizing emergency rooms:

The AMA System of Emergency Room Categorization

Category I — Comprehensive Emergency Service — At least one licensed physician shall be in the emergency department at all times, with physician specialists representing the major specialties and subspecialties available within minutes. Ancillary services including laboratory services, blood bank, x-ray, operating room and intensive care facilities, must be staffed at all times. This category has the capability to deal with all varieties of medical care and has a bed capacity to accommodate direct and referred patient loads.

Category II — Major Emergency Service — At least one licensed physician shall be in the emergency department at all times, with physician specialists representing medicine, surgery, pediatrics, and maternity available within minutes. Ancillary services are staffed 24 hours a day and available to the emergency department at all times. Hospitals in this category may occasionally need to transfer patients for ultraspecialized follow-through care to Category I hospitals.

Category III — General Emergency Service — At least one registered nurse on duty in the hospital is available for emergency service and a licensed physician is "on call" to the emergency department at all times.

Category IV — Basic Emergency Service — A physician and a nurse shall be available either "in house" or "on call" 24 hours a day. Limited ancillary support is "on call" 24 hours a day.

Results

The Committee determined that there are four New Jersey hospitals in Category I, five in Category II, sixty-eight in Category III and nine in Category IV.

Utilizing its own criteria, the Committee determined that seventy-two of the eighty-six hospitals surveyed met the mandatory criteria for all emergency rooms, however, only twelve emergency rooms in all categories met all the criteria for adequacy of care in the various categories, including coronary emergencies,

Table 8
Tabulation of Results
Capable of Adequate Care in Category

Hospital Size Category	Number in Category	Number in AMA Category				Mandatory Criteria	Coro	Chest	Multi-System	Abdomen	Poison	Fracture	All
		I	II	III	IV								
Less than 100	5				5	1	0	0	0	0	0	0	0
100-199	19			16	3	15	7	6	4	9	9	14	3
200-299	22			22		18	3	3	0	6	4	12	0
300-399	19		2	16	1	17	8	5	5	8	4	12	2
400-499	13	1	2	10		13	7	7	5	6	5	10	3
over 500	8	3	1	4		8	4	4	4	4	4	5	4
TOTALS	86	4	5	68	9	72	29	25	18	33	26	53	12

chest injuries, multiple system injuries, and fractures. The results are summarized in Table 8. In each category, less than half the hospitals surveyed were deemed passable, with the exception of the category on fractures, where fifty-three of the eighty-six were acceptable.

There is an obvious relationship between Category I and II and hospital bed size, but the inability of some larger hospitals to pass the specialty care categories was unexpected: only seven out of twenty-one hospitals with four hundred or more beds were found to meet all the criteria in the specialty care categories considered. Conversely, while two-thirds of the hospitals were designated as Category III, indicating a relatively low level of care, three of these hospitals were found to meet successfully all of the criteria for specialty care.

Forty-four hospital emergency rooms surveyed showed a part-time staffing pattern, twenty-three more had physicians (many of whom were "moonlighters") in the employ of the hospital, and nineteen utilized a group plan (any arrangement whereby the Emergency Room physician works for a physician group which bills patients directly for its services) for emergency room physicians.

The Committee calculated the ratio between the number of emergency room physicians and the patient visits per year; the lowest ratio was 1:300; the highest was 1:12,448. The average ratio was approximately 1:4000. Such loads are carried on the basis of an eight hour shift and a forty-hour work week.

Geographically, there are fifty hospitals in the northeast corner of the state (Bergen, Essex, Hudson, Passaic and Union Counties) and there are forty-five emergency rooms in these hospitals. Of the remaining forty-nine hospitals, all of them have active emergency rooms; thirty-six are staffed full time by a physician, on one staffing pattern or another.

All eighty-five hospitals keep some form of emergency room record and the vast majority attempt to integrate these records with their regular record system. Twenty-six hospitals do not have a space for patient consent on the emergency room record. Only seven hospitals review emergency room records on a weekly basis and twenty-one on a monthly basis; fifteen review records infrequently, while forty conduct no review at all.

Audits of emergency room deaths are infrequently conducted. Thirty-nine hospitals reported that they conduct no audit at all and in most instances, no separate audit in the emergency department is conducted.

Discussion

The survey was originally intended to inform hospitals of the Committee's concept of an adequate emergency room. In the course of rechecking data, it has been refreshing to note that a number of improvements have been made as a result of the survey and a number of requests for resurvey have been received.

An additional purpose was to determine how well New Jersey's hospitals fit into the American

Medical Association's categorization system for emergency rooms. There is an obvious relationship between hospital bed size and placement in Category I and II. More than two-thirds of all surveyed hospitals have been designated as Category III facilities.

The Committee's criteria of care, however, provide some contrasts to the AMA system. First, only seven of the twenty-one hospitals with more than four hundred beds were found to meet the criteria for care in the specialized categories. Second, only twelve hospitals met these special care criteria.

The Committee believes that its own criteria provide a more accurate description of the adequacy of care of an institution than the American Medical Association's system. In the event that New Jersey's hospitals are categorized, the Committee feels that its approach, utilizing specific criteria, would be the preferable method.

Some of the present criteria are redundant and failure in one category would result in failure in several others. This is particularly true of two criteria: training in cardiopulmonary resuscitation (CPR) technics and familiarity with equipment and procedures related to various traumatic or disease states. Lack of training for emergency room personnel has been one of the more frequent causes for rejection in the coronary, chest trauma, and multiple system injury categories. Lack of an item of equipment, particularly coronary care monitoring equipment, was a noteworthy cause of rejection. Failure to provide laboratory facilities twenty-four hours a day was damaging to many institutions in the routine care categories.

This survey could not evaluate the quality of the emergency room physicians, nor could it differentiate physicians seriously interested in emergency medicine as a career from those who supplement their income by employment in emergency rooms. This study of physician staffing patterns relative to full-time vs. part-time employment was important since it is well known that "moonlighting" residents seek part-time employment on emergency room staffs. Forty-four hospitals utilize this pattern and this has to be considered a disturbing fact.

The results show that the majority of emergency rooms are staffed by physicians who are not engaged in emergency medicine as a career and whose work is not subject to the same systematic review that is found in the rest of the hospital. Despite the large investments of monies involved (at least \$35,000 per physician, \$10-12,000 per nurse, plus the costs of equipment and space) only twelve emergency rooms in the state have been found capable of rendering care in all specialized categories.

The Committee believes that this statistical report, based on data collected in the field by people with some knowledge of emergency rooms, is reliable. However, the criteria used to judge the adequacy of care are necessarily the products of the Committee's best judgemental opinion and conclusions drawn must be recognized as reflecting these values. These criteria are presented in the accompanying tables (1-7).

Some hard questions are raised by these data. Should every effort be made to remedy all deficiencies in every emergency room with the concomitant spending of additional monies? Should efforts be made to concentrate on developing a three tier system of emergency care, (Minimal — Moderate — Maximal) with all emergency rooms clearly identified as to their individual capacity? In the latter technique, the concentration of monies available might produce more meaningful care than if diffused through all hospitals. Obviously, this is a decision that society, as a whole, will have to reach through its designated representatives.

Conclusions

Eighty-six of the approximately one hundred active emergency rooms in the state have been surveyed. This survey shows that almost half the active emergency rooms in the State of New Jersey are located in the five county northeastern area.

Physician staffing in the emergency rooms is predominantly part time. The emergency room physicians, on an average, are seeing approximately 4,000 patients in a year or roughly two patients per hour. There are numerous examples, however, particularly in urban hospitals,

where the case load approaches six patients per hour.

On the basis of AMA Categorization, four hospitals were in Category I, five in Category II, sixty-eight in Category III, and nine in Category IV.

The employment of part-time physicians and the concomitant lack of emergency room record review by the majority of institutions raises a serious question concerning the level of care being rendered by the emergency room. At this time, it cannot be answered, except to say that

most (72) of the emergency rooms met the minimal criteria for adequacy of care, while few (12) met the criteria for care in all categories of specialized care.

The issue of the best possible way to proceed with the future development of emergency rooms in New Jersey is raised by these data.

Reference

American Medical Association, Commission on Emergency Medical Services: Categorization of hospital emergency capabilities. Chicago, American Medical Association, 1971.

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts (original and one copy) submitted to *The Journal* must be typewritten, *double-spaced* on letter size (about 8½ x 11 inch) paper, and forwarded to the

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Bibliography: Format used in JAMA must be followed. References should be numbered in order of citation in the text.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 21, 1975

A regular meeting of the Board of Trustees was held on September 21, 1975, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Medicaid Regulations — New Jersey . . . Approved the following recommendations concerning fee reductions for physicians and generic drug provisions under Medicaid:

(1) That notification be sent to the Department of Institutions and Agencies, the Governor, and the Department of Health, Education, and Welfare indicating that MSNJ withdraws its support of the Medicaid program as it is administered in New Jersey.

(2) That notification of the above be sent to all members of MSNJ, with the added proviso that the question of whether to render services under the Medicaid program in non-emergency situations is purely a personal decision of the physician.

(3) That MSNJ proceed with an audit of Medicaid books utilizing Society personnel assigned by the Executive Director.

(4) That MSNJ continue to pursue the complaint through the Public Advocate.

(5) That MSNJ seek remedial legislation *to include amendments of Medicaid reimbursement under the Cost of Living Index.* (Italics indicates amendment by the Board.)

(6) That if all of the above fails, litigation as to all issues with a reasonable chance for success be initiated.

. . . Directed that communications to members of the Society pertaining to item #2 include caution of possible charges of abandonment and specific instructions on how this may be avoided.

. . . Directed that the item of Medicaid reimbursement be placed on the agenda for the special session of the House of Delegates.

. . . Directed that the current Essex County Ad Hoc Committee on State Medicaid Providers be appointed as the State Ad Hoc Committee and that additional members be included from other

areas of the State, and that the latter committee prepare a report for submission to the delegates prior to the convening of the special session of the House.

. . . Directed that communications — expressing displeasure with a Board of Medical Examiners' resolution which states that the Board "will institute action including possible suspension or revocation of license of any physician who arbitrarily withholds his services from *his* patients — from Gloucester, Middlesex, Passaic, and Union County Medical Societies be acknowledged with the explanation that the resolution is appropriate because it deals with abandonment of patients by physicians and specifically states "*his* services from *his* patients" — "*his* patients" would be those patients that the physician is actively treating or those with a chronic illness.

Liability Insurance Rate Filing . . . Received the following information from the Executive Director concerning rates for renewal of liability insurance and empowered the President and Chairman of the Board to determine whatever future action should be taken:

The State Actuary has suggested that 3½ percent of the Britton Agency commission be deleted from the filing and billed directly to the insured and that the Chubb component be reduced by 4½ to 5 percent because of "unknown" matters.

Meetings were held on September 3 with Chubb, the Britton Agency, and MSNJ, and on September 9 with Commissioner of Insurance Sheeran and MSNJ.

Chubb has notified the Commissioner that the deadline for rate approval is September 22 and that if not approved non-renewal notices will be sent out.

Note: The Insurance Commission has approved and Chubb and Son has accepted the following rates, effective on policies to be renewed November 1, 1975.

Class	Limits	
	½ to 1½ million	1 to 3 million
1	\$ 1,355	\$ 1,571
2	1,700	1,971
3	2,906	3,367
4	5,719	6,629
5 orthopedics	10,544	12,220
neurosurgery	16,288	18,878
6	837	970
7	532	617
0	723	838

Federal Utilization Review Regulations . . . Received as informative notice that HEW has entered a stipulation agreement with the AMA whereby the contested utilization review regulations will be withdrawn and amended to comply with AMA regulations; the AMA suit was dismissed without prejudice.

Committee on Medical Education Membership . . . Rejected a recommendation that the Committee on Medical Education be enlarged to 15 members to include representatives from the office of continuing medical education of CMDNJ and the Academy of Medicine, since it is already within the Committee's purview to invite non-members to its meetings. It was further noted that to implement such a recommendation would require an amendment to the Bylaws.

. . . Approved a recommendation that the Chairman of the Committee on Medical Education be authorized to invite the various specialty societies to send liaison members, without vote, to attend the meetings.

Unifying Fiscal and Dues Years . . . Approved the following recommendation with the suggestion that the Committee on Revision of Constitution and Bylaws consult with the Committee on Finance and Budget in preparing the amendment:

That the Standing Committee on Revision of Constitution and Bylaws prepare an appropriate amendment to the Society's Constitution and Bylaws unifying the fiscal accounting year and the dues year.

Nominating Procedure . . . Approved the following recommendation:

That the Standing Committee on Revision of Constitution and Bylaws prepare an appropriate amendment to the Society's Constitution and Bylaws in order to accomplish the revisions cited (see below) by the Committee on Long Range Planning and Development.

(1) Nominating Delegates should serve only one three-year term and a maximum of two years of an unexpired term.

(2) The Nominating Committee should be required to meet at least 40 days prior to the opening session of the House of Delegates, and a written report should be mailed with the advance materials to the delegates and printed in the *Membership Newsletter* and *The Journal*.

(3) The procedure of roll call conducted at the meeting of the Nominating Committee should be discontinued.

(4) The Nominating Committee should be conducted by the rules of procedure in effect for the Society in general — those listed in *Sturgis' Standard Code of Parliamentary Procedure*.

(5) The curriculum vitae required by MSNJ on each candidate seeking elective office should be revised to include information other than the candidate's county and State Society activities, as well as his or her views on crucial issues affecting Medicine.

Conference Committee on Inter-Relations with the Judiciary and the Bar . . . Received as informative a report on the August 12th meeting between the Conference Committee on Inter-Relations with the Judiciary and the Bar and the Supreme Court Committee on Relations with the Medical Profession, as a result of which the following recommendation was approved and forwarded to the State Supreme Court:

That the professional liability subpanels operative under Rule 4:21 be made a mandatory procedure in all actions involving medical professional liability.

Hospital Application Forms for Present and New Staff Members . . . Voted to offer appropriate support to any member of the Society who is being denied hospital staff privileges or having such privileges revoked for refusing to sign a hospital application form for present and new staff members which contains the following objectionable section:

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations, and other interested persons, on request, regarding any information the hospital and the medical staff may have concerning me, as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

HEW Ruling Concerning Medicare and Medicaid Admission . . . Directed that in the matter of the action taken by the Board of Trustees concerning Resolution #14 (see page 751, *JMSNJ*, September 1975) the Ocean County Medical Society be informed that the Board of Trustees is the executive branch of this Society when the House of Delegates is not in session, and the Board has the power and the obligation to act when information is received that was not reviewed by the members of the House.

Note: The Executive Director's response to the Ocean County Medical Society's question, "under what authority the Board may override an action of the House of Delegates,"

stated that the decision was based upon legal advice that the regulations in question were undergoing litigation and, since the issue was before the courts and being favorably viewed by them, massive non-compliance or even the urging of it could result in the following:

(a) Charges of obstruction of civil justice by MSNJ and its members

(b) Prejudice to the AMA case

(c) If regulations were upheld and declared effective in July, economic loss to hospitals, patients, and employees attributable to physician non-participation would result in a high volume of litigation accompanied with fantastic economic exposure to MSNJ and its members and real exposure in regard to Federal laws proscribing boycotts.

New Jersey Hospital Association . . . Received as informative the following items from the report of MSNJ's liaison representative to the New Jersey Hospital Association (Dr. Madara):

(a) After discussion of Doctor Bourns' letter of August 6, 1975, recommending amendment of application forms for medical staff membership, it was decided to have this placed on the agenda for the next meeting of the Executive Committees of MSNJ and NJHA.

(b) A motion was passed to oppose the reduction of AID-approved days for Medicaid hospital admissions and the request from Blue Cross for similar reduction for Blue Cross subscribers.

(c) Approved the appointment of Mr. H. Jaffrey as the new representative on the New Jersey Foundation for Health Care Evaluation.

(d) A motion was passed to recommend endorsement of the Medic Alert Program.

(e) A motion was passed to re-endorse the BEST Program (Bio Medical Engineering Service and Technology).

(f) A motion was passed to support the figure of \$100,000 as the cost of health care facilities requiring a certificate of need.

Non-Qualified Personnel as First Assistants at Surgery . . . Directed that the following item be referred to the Council on Medical Services and that the Council work in consultation with the New Jersey Chapter of the American College of Surgeons and the Council on Professional Practices of NJHA for formulation of a State

Society position on the use of non-qualified personnel as first assistants in surgery.

The matter of the State Board of Medical Examiners' censure of South Jersey hospitals for using non-qualified personnel as first assistants at surgery was referred to the Council on Professional Practices for further discussion with representatives of MSNJ.

Radiologic Services' Fee-For-Service Billing . . . Approved the following recommendations from the Radiological Society of New Jersey and agreed to appoint a committee to work with that Society, Blue Cross, and Blue Shield to assist in determining the feasibility of this effort:

(a) That a position of reaffirmation and extension of the guidelines established in "Guides for Physician-Hospital Relations in New Jersey" adopted by the House of Delegates of MSNJ in 1964 be established by this Board.

Note: In this action, the Radiological Society is requesting that the Board support the concept of independent practice, i.e., fee-for-service rendered for all physicians regardless of specialty or site of practice who so desire this manner of professional reimbursement.

(b) That a position statement be formulated expressing the Board of Trustees' support of the efforts of the Radiological Society of New Jersey in urging Blue Cross and Blue Shield to work with the State Radiological Society so that, where indicated, the professional component of in-hospital radiological services would be covered by Blue Shield in a manner similar to other physician services.

AMA Policy Re Publications as Membership Benefit . . . Noted that benefit of membership in the AMA will include *JAMA* and *American Medical News*; specialty journals and other publications will be placed on a subscription basis and prices will be determined by the AMA Board of Trustees.

AMA Membership . . . Noted that MSNJ has been commended for exceeding its year-end 1974 dues-paying AMA membership. The AMA has reached an all-time high in dues-paying membership, which represents the third consecutive year of growth and the second consecutive year for membership record.

November Is Diabetes Month

Superior Court Rule 4:74-7 — Amendment

The attention of our members is called to the recent New Jersey Supreme Court Amendment of Superior Court 4:74-7 which took effect on Monday, September 8, 1975. The new requirements and procedures are summarized as follows:

1. *Involuntary or "Regular" commitments must have:*

- a. two physician certificates typewritten, not handwritten;
- b. two certifying physicians licensed in New Jersey; not just any other state.

2. *At the hearing:*

Only a New Jersey licensed psychiatrist, board-eligible, or certified by the American Board of Psychiatry and Neurology shall give oral testimony following at least one examination of the patient subsequent to the date of the temporary order.

3. *Time limits for the temporary commitment hearing are:*

- a. Class A (NJSA 30:4-25) — 20 days after filing application
- b. Class B — 20 days from temporary order
- c. Class C — 20 days from admission

Requests for adjournment must be exceptional and for good cause only, not to exceed 10 days.

4. *Patient must be represented.*

If the patient is a minor, a guardian will be appointed. In certain cases, a guardian and an attorney will be appointed by the committing court.

5. *Notice of hearing shall be served no less than 10 days before the hearing* to the patient's counsel or guardian *ad-litem*, the applicant, nearest relatives, county adjuster, superintendent of institution, and personally to the patient.

If such notice is mailed to the hospital in the name of the patient, it is the hospital's responsibility to serve the notice to the patient personally.

6. *Patient shall be required to appear at the hearing*, but may be excused from the courtroom during all or any portion of the testimony upon application for good cause shown. Good cause shall include testimony by the psychiatrist that the mental condition of the patient would be adversely affected by the patient hearing his candid and complete testimony. The patient shall have the right to testify in his own behalf but need not. In no case shall the patient appear *pro-se*. However, you may assume that when the patient is seriously ill, or when it would be unduly dangerous to transport the patient, the hospital should either request an adjournment from the court or make provision that the hearing be held on institutional grounds.

7. *No minor shall be committed, except temporarily*, to a mental institution on an application of parent/s or other person in loco parentis. Minors must be committed pursuant to the new commitment process.

8. *Patient's counsel or guardian ad-litem shall have the right to inspect and copy all records* relative to the patient's mental condition. The court may direct an independent psychiatric examination of the patient. The cost of said examination and the psychiatrist's fee for testifying, if any, shall be borne by the person or public body charged with the patient's legal settlement.

9. *If the court finds at the hearing that institutionalization is required, it shall enter a judgment of commitment* if patient is not so confined and treated. It shall provide for review of the commitment no later than (1) six months from the date of judgment, and (2) on or before one year from date of judgment, and (3) annually thereafter, if the patient is not sooner discharged.

10. *A judgment discharging the patient may contain conditions for release* which shall be stated clearly as continuation of these shall be subject to periodic review.

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that frightened engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with his agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progestrone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

ly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might only have to tell the families of the patients to remove the insert from the package.

Implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

The following Policy Statement was adopted by the Board of Trustees of the New Jersey Foundation for Health Care Evaluation at its August 1975 meeting. It reflects our concerns with the status of the PSRO program. It was presented at the Annual Meeting of the American Association of Professional Review Organizations in August, and it was adopted by that body as official policy. Since then, it has been given nationwide distribution through AAPSRO literature.

The response by physicians of New Jersey to the challenge set forth in Section 249F of P.L. 92-603 was energetic, sincere, and genuine. By generously donating their time and knowledge, New Jersey physicians quickly formed a statewide medical foundation and PSRO organizations in each of our eight areas. Medical organizations contributed seed money to help the core groups get started.

Those of us who accepted this challenge did so in a genuine belief that peer review is the best way to assure the quality of medical care, and that physicians were being given the opportunity and responsibility to conduct real peer review. For our efforts, they often gained not applause but brickbats from colleagues accusing them of subservience to government control and abandonment of the traditional independence of the physician to stereotyped mediocrity. Such attitudes can be attributed to a lack of understanding of the original stated intent of the legislation, as well as to failure of recognition that the developing PSROs represent the physicians themselves.

The fledgling PSROs looked toward the day when they would be able to provide genuine service to patients and colleagues in providing guidance and assistance to all concerned in their local areas. They approached this task with eyes open, and with some misgivings. They accepted Senator Bennett's principles that the targets were assessment of quality, necessity, and appropriateness of care, and that the parameters would be measured against local standards and

criteria. They expected that the autonomy of each local PSRO would give it flexibility in dealing with the doctors and institutions in its area, so that procedures would be developed and altered as experience was gained. It was not the intention of these pathfinders to establish a rigid nationwide structure concerned solely with cost control, nor indeed was this the intent of the legislation.

- Thirty months later, we find ourselves entangled in a web of regulations, transmittals, contracts, confusion and delays.

- The beacons of flexibility and autonomy grow dimmer and dimmer when viewed through the accumulated relevant pages of the Federal Register and multiple Transmittals. The image of Senator Bennett has set below the horizon.

- Underfunding has retarded growth and development, by intent or accident. Recession and inflation take the blame, but are the fiscal problems merely excuses for de-emphasis?

- There is increasing disillusion in the ranks of physicians fighting the battle for acceptance of PSRO. Despair and dismay thin the ranks while the fires of opposition increase. With faith and trust in the original federal promise shattered, cynicism is winning. Should physician cooperation die, any hope for a meaningful program fades, and we are left with a rigid, federally imposed sterile system.

- The "new" regulations caused much concern: Are they truly the same as PSRO? If so, why are they necessary? If funds were scarce, why not start one program properly, rather than two? Why not let PSRO develop as originally planned — *or*, is PSRO designed to fit *into* the regulations, and not vice versa?

- Guidelines, rules and definition are becoming more detailed and specific as time goes on. Despite assurances to the contrary, the spectre of rigid nationwide regimentation will not go away (and nothing would be more detrimental to medical care at the local level where it really counts).

- Instructions and proposals permit very little time for response — adequate analysis and consultations are frequently not possible.

- Lack of clear leadership leads to confusion (and potentially to mutiny). The various divisions of HEW — SSA, SRS, OPSR — do not seem to be marching to the same drum. Do all branches believe in the value of PSRO?

- Lack of authority by regional offices hampers PSRO operations. The regional officers are conversant with the personnel and conditions affecting PSROs in their spheres of influence. Reason and logic indicate that they should have increasing authority to make decisions about policies and services. It seems ludicrous to contact Rockville, Maryland on a matter much more familiar to a person in New York City.

- Lack of clear policy on matters of great concern to physicians is a serious deficit at this late date. The matters are confidentiality, medical liability under PSRO and new regulations, and physician reimbursement for mandatory utilization review. These are major points in "selling" these

programs to physicians; they often gauge the sincerity of the advocates on their attitudes on these points.

We therefore make the following policy recommendations:

1. Change from cost reimbursement to a system more compatible with PSRO funding, such as grant funding procedures.
2. Decentralize administrative activities by giving regional offices more authority.
3. Return control of PSRO operations to physicians at the local level, as provided in the law. PSRO operations should be controlled neither by state agencies (who are not physicians' peers) nor by HEW bureaucrats.
4. Provide funds to reimburse physicians for their time spent in mandated activities of PSRO, utilization review, establishment of criteria and standards, and the like, recognizing the countless hours already donated by many physicians.
5. Assure that regulations and policies emanate from a single agency, rather than multiple sources.
6. Grant the emerging PSROs some degree of autonomy and flexibility in arranging their local operations. This will be a strong point in "selling" PSRO membership and participation to the physicians in the area.

In summary, we ask that the original legislative intent be restored to the program; that SRS, SSA and OPSR get together on methods and goals; that PSROs be allowed to succeed (or fail) on their own initiative and efforts; that *quality* medical care be the goal; and that less rigidity would permit the flexibility and autonomy which was promised.

It is hoped that the good intentions and spirit of cooperation do not disappear in the "Rockville Triangle" (Baltimore, Washington and Rockville) and that, with a little more faith and trust in the good judgment of the majority of America's physicians, a peer review system will be established of which we can all be proud.

Readers Please Note

The careful review of *Heroin Addiction in Britain: What Americans Can Learn from the English Experience*. H. F. Judson. New York, Harcourt Brace Jovanovich, 1974 (JMSNJ 72:780, September 1975) was prepared by A. Johan Noordsij, M.D., one of our regular book reviewers. Through a printer's error his name was misplaced and did not appear at the close of the review.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of August 12, 1970: Section 3685, Title 39, United States Code)

1. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

2. Date of Filing October 1, 1975.

3. Frequency of Issue: Monthly.

3-o. Annual Subscription Price: \$10.

4. Location of known office of publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the headquarters of general business offices of the publishers: 315 West State Street, Trenton, New Jersey 08618.

6. Names and addresses of publisher, editor and managing editor: Publisher, The Medical Society of New Jersey, 315 West State St., Trenton, New Jersey 08618. Editor, Arthur Krosnick, M.D., 315 West State St., Trenton, New Jersey 08618. Asst. Editor, Mrs. Marjorie Treptow, 315 West State St., Trenton, New Jersey 08618.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): The Medical Society of New Jersey, 315 West State St., Trenton, New Jersey 08618 (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: none (a non-profit corporation of New Jersey).

9. For optional completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U. S. C. 3626 provide in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter of such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 of the reduced postal rates authorized by 39 U. S. C. 3626. (Signed)

Robert H. Lombert, Business and Financial Manager
The Medical Society of New Jersey

10. For completion by non-profit organization authorized to mail at special rates (Section 132.122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

11. Extent and nature of circulation:

	Average no. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total No. copies printed (Net Press Run)	9,631	9,750
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail subscriptions	9,117	9,161
C. Total Paid Circulation	9,117	9,161
D. Free Distribution by mail carrier or other means — samples, complimentary, and other free copies	331	332
E. Total Distribution (Sum of C and D)	9,448	9,493
F. Copies Not Distributed		
1. Office use, left-over, unaccounted, spoiled after printing	183	257
2. Returns from news agents	—	—
G. Total (sum of E & F—should equal net press run shown in A)	9,631	9,750

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Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. Should patients receiving major tranquilizer therapy receive antiparkinson drugs prophylactically?

The antipsychotic agents produce a wide variety of untoward effects including extrapyramidal reactions. The piperazine compounds* and haloperidol (Haldol[®], McNeil) more often than the aliphatic compounds** produce a parkinsonian syndrome and akathisia. (The piperidine compounds*** are least likely to produce these reactions.) The piperazine compounds and haloperidol also are more likely to induce dyskinetic reactions, especially in younger patients. A rare syndrome, tardive dyskinesia (rhythmic movements of tongue, jaw, and face), occurs in older patients after prolonged administration of antipsychotic agents, and may persist after termination of therapy.¹

In order to control these drug-induced extrapyramidal reactions, a number of synthetic antispasmodics with anticholinergic activity have been prescribed. These antiparkinson agents proved so successful in reducing or relieving these extrapyramidal reactions, that they began to be used

routinely and extensively for patients given antipsychotic medications.² Recent studies have suggested that the prophylactic use of antiparkinson agents may be unnecessary.²⁻⁵ In addition, it has been hypothesized that a deficiency of acetylcholine activity exists in patients with tardive dyskinesia. An anticholinergic agent which further antagonizes acetylcholine would be expected to increase the patient's risk of developing this syndrome,⁶ which is frequently irreversible.⁵

During a two year period at the Massachusetts Mental Health Center, 62 percent of 555 patients admitted were placed on pharmacotherapy; of these 38 percent were also given antiparkinson drugs. Of the latter group, 59 percent received an antiparkinson agent after a side-effect had been observed, but 38 percent were started on an antiparkinson drug at the same time they initially received a psychotropic drug. The lowest incidence of side effects was noted in those patients who never received an antiparkinson drug, and after examining the incidence of extrapyramidal symptoms in the other groups, it was obvious that the administration of antiparkinson drugs did not preclude the occurrence of these symptoms. In fact, rigidity and akathisia actually was observed slightly more frequently in patients who had undergone the prophylactic regimen.²

Stratas and co-workers³ evaluated 88 female patients receiving antiparkinson drugs secondary to phenothiazines for extrapyramidal movements disorders. When the antiparkinson drugs were discontinued over a nine week period, 64 percent showed no extrapyramidal symptoms. The remaining 24 patients were divided as follows: 16 were placed on reduced dosages of the same phenothiazines and 8 were switched to thioridazine (Mellaril[®]). Of the 16 patients placed on reduced dosage, 13 were free of extrapyramidal symptoms when re-evaluated at two weeks; the remaining three responded to thioridazine. All eight patients placed directly on thioridazine lost their extrapyramidal symptoms. The author concluded that 75 percent of patients receiving phenothiazines do not need antiparkinson agents, and the remaining 25 percent respond to reduction of dosage or transfer to thioridazine.

Orlov *et al.*⁴ withdrew the antiparkinson medication from 78 patients also receiving antipsychotic medications. Only 9 percent showed a recurrence of symptoms requiring the restarting of the antiparkinson medications.

In conclusion, studies have shown that it is not necessary to administer antiparkinson drugs prophylactically to all patients at the outset of major tranquilizer therapy. In fact, antiparkinson drugs may increase the incidence of tardive dyskinesia by lowering the threshold for the appearance of these movements.^{5,7} If an antiparkinson agent is administered after the onset of appropriate symptoms, it should be discontinued after four to six weeks, and the patient re-evaluated.⁵

*The piperazine group of antipsychotic compounds includes, fluphenazine (Prolixin,[®] Permitil[®]), perphenazine (Trilafon[®]), prochlorperazine (Compazine[®]) and trifluoperazine (Stelazine[®]).

**The aliphatic group of antipsychotic compounds include, chlorpromazine (Thorazine[®]), promazine (Sparine[®]) and thiorpromazine (Vesprin[®]).

***The piperidine group of antipsychotic agents include, thioridazine (Mellaril[®]), and mesoridazine (Serentil[®]).

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⁷Klawans H L and Rubovits R: Effects of cholinergic and anticholinergic agents on tardive dyskinesia. *J Neurol Neurosurg Psychiatry* 25:410-412 (November) 1971.

2. What information do you have regarding the use of nitroglycerin in acute myocardial infarction?

The fear of hypotension associated with acute myocardial infarction is understandable when one considers the poor prognosis of patients who develop cardiogenic shock. In such patients the hypotension often results from pump failure due to massive myocardial damage. Diminished arterial pressure undoubtedly plays a role in the high mortality associated with cardiogenic shock.

Until recently the dogma that the hypotension produced by nitroglycerin contraindicates its use in patients with acute myocardial infarction went untested. Surprisingly, several studies now suggest that certain vasodilators, in spite of their hypotensive effect which may be deleterious, still can be of overall benefit by preserving borderline ischemic myocardium thus reducing infarction size.¹ The amount of myocardial ischemia can be measured by a technique which quantitates the elevation of ST segments utilizing serial precordial mapping studies.² The exact mechanism by which nitroglycerin and other vasodilators exert this beneficial effect is unknown. Although the relationship between hypotension and ischemic injury is complex, nitroglycerin appears to increase blood flow through collateral arteries and to redistribute blood flow toward the endocardium, both of which should favor survival of ischemic areas.

Redwood and associates³ assessed the effects of nitroglycerin on experimentally produced ischemic injury to the myocardium of dogs, and showed that nitroglycerin resulted in diminution of injury.

Williams, et al.⁴ gave 0.4 mg of nitroglycerin sublingually to 16 supine patients during the first 72 hours of acute myocardial infarction, and determined the hemodynamic effects serially over 30 minutes. Nitroglycerin was effective in decreasing hemodynamic determinants of myocardial oxygen demand.

Flaherty, et al.⁵ gave intravenous infusions of nitroglycerin (a product not commercially available) to 12 patients with acute myocardial infarction. In all six patients for whom serial precordial mapping studies were done, findings were

suggestive of improved left ventricular function and of decreased myocardial ischemia. Delgado and co-workers⁶ suggest similar findings in certain patients utilizing 0.3 mg of sublingual nitroglycerin.

In conclusion, the long-standing clinical admonition not to administer nitroglycerin to patients with acute myocardial infarction needs re-evaluation. Nitroglycerin may prove to be useful in select patients during acute myocardial infarction, as the drug has been shown to decrease myocardial ischemia. Further study is needed to select those patients who may benefit from nitroglycerin therapy during acute myocardial infarction.

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3. Is there any advantage of continuous infusion administration of heparin over the intermittent bolus?

Because of unpredictable absorption of heparin from extravascular sites, most authorities favor the intravenous route for heparin administration in therapeutic doses, and subcutaneous injection is reserved for "mini-dose" prophylaxis against venous thromboembolism.¹ There is, however, disagreement concerning the preferred method of intravenous injections, that is, continuous versus intermittent injections and the safety and efficacy of these two techniques of intravenous administration.

Spracklen, et al.² pointed out that one of the most important disadvantages with intermittent therapy is the rapid peak of heparin following bolus infusion and the rapid decline in blood levels to below therapeutic levels, leaving the patient "unprotected" for the last period. The period immediately following the injection also subjects the patient to grossly prolonged clotting times which might predispose the patient to hemorrhagic complications.

Salzman, et al.¹ conducted two studies to compare the effects of intermittent and continuous infusion heparin therapy. Before starting the continuous infusion study, 100 patients receiving conventional intermittent intravenous heparin boluses at four-hour intervals were observed. Major bleeding occurred in 21, and minor bleeding in 16. Two patients died from bleeding, and two had recurrent pulmonary embolism. Major hemorrhage occurred in 21 per cent when therapy was regulated with whole-blood clotting time and in 20 percent when heparin was given without clotting tests.

In a subsequent prospective trial, patients received heparin by intermittent intravenous injection with or without laboratory control according to the partial thromboplastin time or continuously by intravenous infusion with laboratory control. Recurrent thromboembolism occurred once in each group. Major bleeding was seven times more frequent with intermittent injection than with continuous infusion. Control with the partial thromboplastin time did not prevent major bleeding in patients receiving intermittent injections. With continuous infusion, one-fourth less heparin was required than with intermittent injections.

Kingdon,³ however, pointed out that if continuous therapy was given by intravenous drip, the practical question of the adequacy of monitoring the rate of drip arises. Frequently, the intravenous solution runs too fast or too slow, so that the heparinization is erratic. This problem can be solved by the use of a continuous infusion pump, but these pumps are expensive, and it may be difficult to provide enough for all the patients in a hospital who require them.

Swanson and Cacace⁴ listed the following as the advantages of a continuous infusion method over the intermittent bolus:

1. Clotting time can be maintained continuously in therapeutic range.
2. Neutralization with protamine sulfate, if necessary, is immediate.
3. Less heparin is required by this method than by any other.
4. Clotting time can be done at any time.
5. Flexibility in dose adjustment exists.
6. Clotting time returns to normal levels one to two hours after drip has stopped.
7. Fewer hemorrhagic complications occur.¹

In conclusion, it appears that the administration of heparin by continuous infusion is safer than intermittent injection and is no less effective for prevention of thromboembolism.

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Physicians' Relief Fund

The Physicians' Relief Fund of The Medical Society of New Jersey is available to members of MSNJ in need of financial assistance in time of emergency or catastrophe. Applications are made through your county medical society—write or call the Secretary or the Executive Secretary for information.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.

President, CMDNJ

CMDNJ's New Jersey Medical School, Newark, recently sponsored a thought-provoking colloquium on primary care. The subject is of such intense, current interest, that this space will be devoted entirely to a report on the discussions as provided by Dr. Edward A. Wolfson, associate dean for health care and acting director of the school's new Office of Primary Health Care Education, who was general chairman of the colloquium.

Various aspects of primary care and the problems of access into the health-care system came under intensive review in a day-long "Colloquium on Primary Care" held on September 11 in Newark. The program, attended by 200 physicians and other health care providers, was sponsored by the Office of Primary Health Care Education of the New Jersey Medical School of the College of Medicine and Dentistry of New Jersey (CMDNJ).

Speaking in the large sense — as opposed to day-in, day-out activities of individual physicians — Stanley S. Bergen, Jr., M.D., CMDNJ's president, set the tone for the day's discussions by asserting that the health care system has "failed to be responsive" to the needs of the total public. His thesis was rarely challenged.

"We seek cures and spend huge sums on rare or terminal diseases, while many want for simple health counseling," Dr. Bergen said in his keynote address. He continued:

"It seems as if we have succeeded in providing quality and dramatic advances in medical care and yet have failed to be responsive to the needs of the public for improved health. The challenge is to maintain quality while improving quantity through greater access to health care."

The call for the colloquium broadly defined primary care medicine as first contact care, involving frequently needed, basic medical services and long-term continuity in individual and family care. At CMDNJ, recognition of the need and a dramatic implementation of a solution at the educational level — a program implicitly supported by many of the day's discussion participants who suggested that schools of

medicine had to take the lead — has been the establishment of the Office of Primary Health Care Education in the CMDNJ-New Jersey Medical School. With the ink of the announcement barely dry, more than 35 students signed up for senior primary-care elective clinical clerkships.

With that kind of background at the educational level, it is not surprising that the colloquium attracted as co-sponsors the Academy of Medicine of New Jersey, the New Jersey Chapter of American Academy of Pediatrics, the American College of Physicians (New Jersey Chapter), The Medical Society of New Jersey, the New Jersey Academy of Family Physicians, and the New Jersey Osteopathic Association.

Speeches aside, the colloquium day was divided into a morning panel discussion, "Approaches to a Common Challenge," with David E. Rogers, M.D., president of the Robert Wood Johnson Foundation, as moderator, and afternoon discussion groups. Members of the morning panel chaired the afternoon discussion groups, as follows:

Paul C. Brucker, M.D., alumni professor and chairman of family medicine, Jefferson Medical College, "The Family Practitioner Views The Internist;" Robert J. Haggerty, M.D., former professor and chairman of pediatrics, University of Rochester School of Medicine and Dentistry, "Family Practitioner — The Only Primary Care Practitioner?"; Lucie S. Kelly, R.N., Ph.D., acting director, CMDNJ-Office of Consumer Health Education, "Primary Care: Sole Domain of The Physicians?"; Edward Rubenstein, M.D., associate dean for postgraduate education, Stanford Medical Center, "Identity Crisis In Internal Medicine?"; and Robert M. Sigmond, M.A., executive vice president, Albert Einstein Medical Center-Philadelphia, "Health Planning For Primary Care: Does It Make a Difference?"

Echoing Dr. Bergen's "Crisis of Access" theme, the day's summary speaker, Philip R. Lee, M.D., former assistant secretary of health of the U. S. Department of Health, Education and Welfare, noted that a low ratio of primary-care-physicians-to-population had resulted from the trend toward medical and surgical specialization

since World War II. Dr. Lee, who is currently professor of social medicine at the University of California, San Francisco, addressed himself to "Primary Health Care: Fad or Foundation of the Health Care System?" Noting that in 1931, 80 per cent of physicians were considered generalists, compared with 20 per cent in 1969, with the greatest decline in urban areas, he said:

"In most states, Medicaid reimbursement for physicians' services is too low to attract private physicians to provide care for the poor. Unless other actions can be taken to deal with poverty, poor housing, crime and other ghetto problems, the provision of care in these areas will be dependent on institutionally based practitioners and public systems of transportation to bring the patients to health centers or hospitals for care."

Dr. Lee said further that the role of medical schools in helping to correct both the geographic maldistribution of physicians and the mix of specialists may be of critical importance during the next 10 to 15 years.

"The extent to which these schools can establish, support, and expand residencies in primary care specialties will be crucial to meeting the needs for primary care specialists," he said.

The maldistribution of physicians — and the part that plays in the access problem — was also dealt with by James G. Haughton, M.D., executive director, Health and Hospitals Governing Commission of Cook County, Chicago. In a luncheon speech on "The Challenge of Equitable Access," he said:

"There is in the U.S. an inverse correlation between the distribution of needs and resources where health manpower is concerned. Physicians and other health professionals tend to flock to affluent areas even though it is known that illness is usually more prevalent among the poor.

"The result is that hospital inpatient utilization is distorted when relatively uncomplicated illnesses are treated in the hospital, because there is no reasonable primary care alternative."

Dr. Haughton cited a change in social values as one answer to the access problem. Today's

medical students are "rejecting the financial and material goals of their fathers and are committed to changing the elitist image of the health professions," he said, continuing:

"If we can nurture this growing interest in social goals on the part of health professionals and combine it with a full partnership for the consumer in our health enterprise, it may be possible for us to begin the redefinition of the goals of a health system . . . 'Health' may, indeed, finally become a state of being to be guarded and prized by the individual possessing it, rather than a gift endowed by a benevolent health system."

Dr. Bergen called for a "return to an era of willingness to care" as a means of dealing with the problem of access. He said:

"I believe it behooves all medical practitioners, medical bureaucrats, public health officials and health professions' educators to join in formulating the plan by which all citizens will have access to health care and become recipients of the benefits of medical knowledge gleaned from the research of recent decades.

"Unfortunately, too often medical schools have been guilty of educating their students today in yesterday's mode of practice, without taking cognizance of the appropriateness of models that we have provided.

"We have, thus, failed to prepare our students for the future and, in many cases, may have retarded progress by graduating generations of students who were, in fact, exposed to patterns of practice that had become outmoded by the advances of technology and society."

Dr. Bergen urged that all students now in medical school "learn the multiple roles that they shall play in the future," not only as deliverers of medical care but as organizers of health care delivery programs for their patients. He also urged physicians to take on a "posture of caring," and he recommended that they provide easy access to health information.

"We have neither shared with the public the decision-making process, the allocation of resources and the determination of priorities,"

he said, "nor have we provided them with the information necessary for the public to assume a role . . . and take responsibility for a measure of their own health care, health maintenance and improved well-being."

New Jersey Requires Hospitals To Plan

The following item was prepared by Charles F. Pierce, Chief, Personal Health Planning and Coordination — Health Planning Development, New Jersey State Department of Health.

Effective July 9, 1975, the State of New Jersey requires hospitals to develop long-range plans. The regulation adopted by the Health Care Administration Board gives hospitals 18 months to submit their plans to the Department of Health.

Legislative Requirements — "No health care facility shall be operated unless it shall . . . prepare and review annually a long-range plan for the provision of health care services. . . ." This section in the New Jersey Certificate of Need law which was passed in 1971 remained largely ignored because of the pressures of implementing certificate of need. The federal government apparently has had the same experience. The Social Security Amendments of 1972 (P.L. 92-603) in Section 234 require institutional planning of those institutions receiving medicare or medicaid funds. Section 234 has taken a back seat to Section 1122. Although federal officials protest the suggestion that Section 1122 is a national certificate of need program, there are many parallels. One of the parallels is the staging of the implementation. The New Jersey and federal experiences of concentrating on the review and approval or denial of major institutional changes and postponing efforts to stimulate institutional plans are identical.

Periodically State Health Planning Council members and area-wide planning agency personnel raise questions about the relationship of specific certificate of need applications to the long-range plans of the institution. A related question was, "If we approve this, are we

obligating ourselves to approve a future application for related support services or equipment?"

Developing Guidelines — An Advisory Committee, chaired by a hospital administrator who was also a member of the council, was given the task of developing the detailed requirements for institutional planning. The committee of seven had a representative from the state hospital association, the state medical society and one staff member from each of the four area-wide planning agencies. There were no consumers. Periodic review sessions were held with a planning advisory committee created by the state hospital association.

The leadership of the New Jersey State Department of Health, which took great interest in the work of the committee, had one major objective. Hospitals should look to their communities and the medical needs of those communities as the primary purpose of their plans. Institutional needs for prestige and power should become secondary concerns.

The committee met monthly with major staff support supplied by the state health planning agency. Two issues divided the committee. Should the requirements for planning be brief and encourage maximum flexibility or detailed and encourage uniformity in approach but flexibility in content? The second issue was the extent of and responsibilities for the data base.

The first issue was resolved by a compromise. The committee developed a detailed "Planning Guide for Hospital Long Range Plans." The guide describes the necessary steps a hospital should take to prepare for planning, a planning process, and identifies the products of the process that should appear in the plan document. The formal regulation is short. It lists twelve items that must be in the plan. The regulation refers to the planning guide as describing *one* way to satisfy the requirements of the law.

The recommended data base is also a compromise. Institutional representatives desired specific data about the municipalities they serve.

The state is able to provide data only at the county level. The planning guide says that the county is an acceptable unit for describing the service area. For most hospitals in the nation's most densely populated state, the county is too large to be useful. Hospitals are encouraged to get data that are appropriate to their service area on their own. Planning agency staff desired extensive data about the institution itself. The compromise was to ask for data required by the state's licensing and inspecting procedures and rate-setting program. The entire data-base is viewed as tentative and will be subjected to intensive review.

Expectations — Hospitals are required to submit two copies of their long-range plans 18 months after publication of the regulation in July 1975. The state will review the plans to insure that they comply with the regulations.

In no way will the state review mean or imply approval of institutions' future intentions or expectations. One copy of the plan stays with the state and the other goes to an area-wide planning agency. All plans are considered public documents.

In designing the regulation and the planning guide the committee desired to be compatible with federal regulations. The requirements of Section 234 are incorporated in the state requirements. The planning process described in the guide is the rational model often referred to as "goal-oriented planning." This process was used by the State's Comprehensive Health Planning Agency and is compatible with the planning process implicit in the new "National Health Planning and Resources Development Act," P.L. 93-641.

Future Health Systems Agencies which will replace the area-wide planning agencies will have a rich resource in their area's hospital long-range plans. These plan documents can be used as a basis for identifying gaps in services and unmet needs. The plans can also be the basis for planning and negotiating among hospitals desiring to implement specialized services requiring a large population base. The agency will have an improved view for its allocation activities.

Physicians should become involved in this planning process at the institutional level and the area level. Many of the changes that will take place in the health care system will take place within the context of the area-wide planning agency's activities. The interaction between institutional long-range planning and the agency's planning will be critical to the dialogue that precedes these changes. Other health care institutions also will be required to develop long-range plans.

There are enormous opportunities in this process. Since all the plans are public, there is an impetus for mutually beneficial cooperation among institutions. More significant is the opportunity for an institution to gain support for its program and future intentions. Active cooperation with the planning agency will identify future hazards and opportunities quickly. Planning agencies will have developmental funds available to grant to institutions that are willing and capable of carrying out programs that will help implement the agency's plans. Here is the chance for a significant partnership between the provider and the planning agencies for the benefit of the community.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY — Socorro D. Tamase, M.D., 225 South Crandall, Los Angeles, California 90057. Santo Tomas (Philippines) 1956. Board eligible. Group, solo, partnership, or hospital. Available.

Sami Emel Basaranlar, M.D., 30 Hasbrouck Road, Staten Island, New York 10304. University of Istanbul 1954. Group, partnership, solo. Available.

DERMATOLOGY — Robert Schneider, M.D., 1945-16 Eastchester Road, Bronx, New York 10461. Brussels 1971. Board eligible. Solo, partnership, or group. Available.

GENERAL PRACTICE — Leonard S. Spoto, Jr., M.D., 1929 Sioux, Glendale, Arizona 85307. Wake Forest 1971 Group (no OB). Available July 1976.

Nellie Lee, M.D., 175 Hobart Street, Ridgefield Park, New Jersey 07660. Far Eastern (Philippines) 1966. Subspecialty, cardiology. Board certified. Group, partnership, clinic, or solo. Available.

Leslis C. Feigin, M.D., 361 Park Ave, Apt. B-2, Orange, New Jersey 07050. CMDNJ 1973. Board eligible. Group or partnership in northern New Jersey. Available July 1976.

Ishwar V. Thakkar, M.D., 1926 West Harrison Street, Apt. 1110, Chicago 60612. Baroda (India) 1970. Subspecialty endocrinology. Board eligible. Group, associate with teaching hospital. Available July 1976.

INTERNAL MEDICINE — Bernard M. Aaron, M.D., 200 Flower Drive, Lexington Park, Maryland 20653. SUNY — Downstate 1969. Subspecialty, gastroenterology. Board certified. Group or partnership as gastroenterologist. Available July 1976.

John E. Madsen, Jr., M.D., 135 Florence Road, Apt. 2C, Branford, Connecticut 06405. Cornell 1968. Subspecialty, gastroenterology. Board certified. Partnership, group, or hospital-based practice. Available.

K. S. Lakshmi Narayanan, M.D., 27300 Parkview Blvd., Apt. 7308, Warren, Michigan 48092. Stanley (India) 1970. Subspecialty, gastroenterology. Board eligible. Group or partnership. Available July 1976.

Dennis Gort, M.D., 822 President Street, Apt. 4, Brooklyn, New York 11215. SUNY, Downstate 1972. Subspecialty, pulmonary medicine. Board certified. Group or institutional. Available July 1976.

Wilhelmina M. Cruz, M.D., 495 East Seventh Street, Apt. 6D, Brooklyn, New York 11218. Santo Tomas (Manila). Subspecialty, nephrology. Board eligible. Dialysis or hypertension program with opportunity for private practice in group, partnership or solo. Available.

Kevoork Cileli, M.D., 1311 Palisade Avenue, Fort Lee 07024. Ankara 1957. Board eligible. Partnership or solo. Available August 1976.

NEUROLOGY — Harry L. Bremer, M.D., 3005 Scarborough Road, Cleveland Heights, Ohio 44118. Hahnemann 1971. Board eligible. Partnership. Available July 1976.

OBSTETRICS AND GYNECOLOGY — Chia Sheng Shu, M.D., 1564 St. Johns Place, Brooklyn, New York 11213. Taipei (Taiwan) 1968. Board eligible. Solo, group, or partnership. Available.

Lyle J. Breitkopf, M.D., 519 Maitland Avenue, Teaneck 07666. SUNY (Downstate) 1960. Board certified. Academic position (full-time) or group practice. Available.

Murray R. Master, M.D., Box 155, Barnes Hospital, St. Louis, Missouri 63110. Pennsylvania State 1973. Board eligible. Group or partnership. Available July 1976.

Stephen M. Woodruff, M.D., 1426 Avon Place, Pittsburgh, Pennsylvania 15221. Jefferson 1970. Board Eligible. Group or partnership in mid or southern New Jersey. Available July 1976.

OPHTHALMOLOGY — Ronald S. Lorfel, M.D., 1505 Vicksburg St., Belleville, Illinois 62221. Wayne State University 1970. Board eligible. Solo, associate, or group. Available July 1976.

Richard L. Tax, M.D., 1605 Park Towne Place, Philadelphia, Pennsylvania 19130. Cornell 1970. Board eligible. Group, partnership, or solo. Available June 1976.

Alan L. Schein, M.D., 119 Upland Terrace, Bala-Cynwyd, Pennsylvania 19004. Jefferson 1969. Board eligible. Group or partnership. Available July 1976.

Ghulam Dastgir, M.D., 614 Troy Avenue, Brooklyn, New York 11203. King Edward, Lahore (Pakistan) Board eligible. Group or partnership. Available July 1976.

ORTHOPEDIC SURGERY — Ira Spar, M.D., 26 Allston Street, Apt. 1, Allston, Massachusetts 02134. George Washington 1968. Board eligible. Group, partnership, or hospital. Available.

Ilhwan Kim, M.D. 1935-16-C, Eastchester Road, Bronx, New York 10461. Seoul (Korea) 1969. Solo or group. Available July 1976.

PEDIATRICS — Lawrence Schaffer, M.D., 3726 Lankenau Road, Philadelphia, Pennsylvania 19131. Einstein 1971. Group, partnership, or solo. Available July 1976.

M. Patricia Fiorentino Baran, M.D., 7603 Foxhall Lane, Richmond, Virginia 23228. SUNY Downstate 1972. Board eligible. Group. Available July 1976.

John Motley, M.D., 103 Poplar Lane, Lexington Park, Maryland 20653. Jefferson 1971. Board eligible. Group or partnership (willing to purchase). Available July 1976. Telephone (301) 862-3525)

RADIOLOGY — Robert J. Baran, M.D., 7603 Foxhall Lane, Richmond, Virginia 23228. SUNY Downstate 1972. Board eligible. Group or hospital based. Available July 1976.

SURGERY — Yusooff T. Allian, M.D., 26710 Golfview Rd., Dearborn Heights, Michigan 48127. Far Eastern (Philippines) 1967. Subspecialty, cardiothoracic surgery. Board certified in general surgery. Group, partnership, association, or solo. Available July 1976.

Achyutananda Roy, M.D., 5601 Boulevard East, Apt. 20-I, West New York, New Jersey 07093. Calcutta (India) 1961. Board certified. Group, partnership, or solo. Available.

Sheldon Kneller, M.D., Box 542, Martin Army Hospital, Fort Benning, Georgia 31905. Einstein (NY) 1968. Subspecialty, vascular surgery. Board eligible. Group or partnership. Available August 1976.

Shuban K. Moza, M.D., 1819 Williamsbridge Road, Apt. 2-A, Bronx, New York 10461. Kashmir (India) 1965. Board eligible. Group or partnership. Available.

Dara Vahid, M.D., 200 Carman Avenue, #12D, East Meadow, New York 11554. University of Tehran (Iran) 1964. Board eligible. Group or partnership. Available July 1976.

Elmer D. Geniblazo, M.D., 184 Estaban Drive, Camarillo, California 93010. Far Eastern 1962. Group, solo — will consider general practice. Available November 1975.

UROLOGY — Harvey Mannes, M.D., 6916 Sprucewood Drive, Lawton, Oklahoma 73501. Jefferson 1968. Board eligible. Association leading to partnership or multispecialty group. Available July 1976.

Jonathan N. Goodson, M.D., 350 East 17th Street, Apt. 12-E, New York 10003. Georgetown 1971. Group, partnership, solo. Available June 1976.

Bernard Schaaf, M.D., 1000 Langworthy, Dubuque, Iowa 52001. Washington University (St. Louis) 1962. Board certified. Partnership or group. Available March 1976.

Kasturi G. Shanker, M.D., 101-4 Van Buren Road, Voorhees 08043. Madras (India) 1960. Group, partnership, solo, or hospital-based. Available July 1976.

Richard A. Fraser, M.D., 15 Rose Loop, Fort Leavenworth, Kansas 66027. St. Louis 1969. Board eligible. Group, partnership, or academic. Available July 1976.

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INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

SUPPLIED: 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

Also available: Cardilate®-P brand erythryl Tetranitrate with Phenobarbital* (Warning: may be habit-forming).

Russek HI: AM J M Sc 239:478, 1960



"Pain days" significantly reduced with Cardilate® (erythryl tetranitrate) in 48-patient study.¹ Patients on placebo experienced same pain as usual or increased pain 2 days out of 3... compared to 1 day out of 4 while on Cardilate.

Rapid-acting chewable tablets (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.



Effective prophylaxis against attacks; increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

Cardilate can save patients money; is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.



ellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Both often



Predominant
psychoneurotic
anxiety

Associated
depressive
symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Use with caution in addiction-prone individuals under cal-

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, though primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium[®] (diazepam) 2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants may potentiate sedation. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Oral Hypoglycemics: Much Heat, Little Light

By now, the UGDP prospective study of tolbutamide and phenformin diet and insulin has been written and editorialized about so much that almost no physician can be unaware of the controversy which has raged in and out of the courts, government offices, newspapers, editorial pages of medical journals, lecture halls, and elsewhere. It is hard to believe that this acrimony, which threatens to go on for years, has continued since 1970.¹ In a commentary in *The Journal* in 1971, Brandman concluded:

"... in the opinion of most investigators and clinicians, the UGDP study did not present convincing evidence that the oral hypoglycemic agents are contributing to the increased cardiovascular death rate."²

What has happened since the original reports and reactions?

1. The FDA proposed a label change for all oral hypoglycemic agents (although only tolbutamide and phenformin were tested) which warned of increased risk of cardiovascular mortality and called for patient participation in the selection of therapy for maturity-onset diabetes.

2. In 1971 the Committee on the Care of the Diabetic (CCD) petitioned the Commissioner of the FDA to modify the proposed labeling to acknowledge the other side of the controversy.

3. In June 1972, the Commissioner denied the relief sought by the CCD, which then filed a class action suit against the FDA. The District Court issued a preliminary injunction and the matter was ordered back to the agency for further consideration.

4. On July 31, 1973, the U.S. Court of Appeals reviewed the matter and remanded the case to the FDA for its further determination.

5. In February 1975, the Biometric Society published a "Report of the Committee for the Assessment of Biometric Aspects of Controlled Trials of Hypoglycemic Agents."³ This group concluded: "We consider that in the light of UGDP findings, it remains with the proponents

of the oral hyperglycemics to conduct scientifically adequate studies to justify the continued use of such agents."

6. At the same time a *JAMA* editorial extrapolated the UGDP report and warned that "10,000 to 15,000 such unnecessary deaths occur each year in the United States alone."⁴ This was followed by a covey of letters to the editor, counter-editorials, and commentaries by opposing authorities who disagreed with the Biometric Society, the *JAMA* editorials, and the UGDP study as reported.⁵⁻¹⁰ The Biometric Society report was "greeted with skepticism by leading investigators and clinicians in Europe."¹¹

7. In August 1975, the FDA held public hearings to receive further testimony before going ahead with the new oral drug label and change in the package inserts. Highlights of the meeting included a new British study by Professor Harry Keen of the University of London and a statement by one of the original UGDP investigators, Angela Bowen, who raised the question of "conflict of interest" by one of the investigators and said some of the cardiovascular deaths ascribed to tolbutamide appeared to be related to non-diabetic factors. A Ralph Nader representative demanded "written consent by patients taking the oral products."

8. Neil L. Chayet, attorney for CCD, as a result of the August 1975 testimony, has "requested an adjudicatory, trial-type hearing to explore in depth the issues which were raised."

What has the UGDP study, which cost nearly eight million dollars and took eight years, accomplished?

1. It has forced physicians to renew their interest in dietary therapy for diabetes.

2. It has stimulated physicians to consider insulin therapy in diabetic patients who were poorly controlled by oral hypoglycemic drugs.

3. It has strained the relationship between doctor and patient. The physician is asked to let the patient make the decision — diet, insulin, or pills — and still be responsible in the long run.

4. It has raised the specter of "informed consent" and written, signed statements — a situation which is both threatening and non-protective in this instance.

5. It has set a precedent, which is to be abhorred — initial reporting of the results of complex medical research to the public through the media (television and newspapers) at a time when no report in the medical literature was available to physicians to read and to prepare for the onslaught of patient queries.

6. It has cast clinical research in a very bad light to the Congress, the American public, and the world, as expensive, controversial, and pointless.

7. It has stimulated a government agency, the FDA, to literally dictate a method of treatment in such a way that the physician who treats the diabetic patient in a contrary fashion leaves himself open to criticism and potential legal action.

8. It has split the cream of United States diabetologists and diabeticians, at the highest level of university and clinical stature, into two camps — pro-UGDP and anti-UGDP.

9. It has cast aspersions on the highly respected field of biometrics and suggests that there may be some truth to that old saw — "figures don't lie, but liars do figure," or the other aphorism related to computers — "garbage in, garbage out."

Where does all this leave the physician who treats patients with diabetes?

1. He should make a major effort to use diet therapy, with weight reduction where indicated, as primary treatment for diabetes.

2. He should not hesitate to start insulin therapy, where diet alone does not control the diabetes, or where complications such as infection are present, during pregnancy, or where surgery is needed.

3. He should not be afraid to order the oral hypoglycemic drugs if the patient cannot or will not take insulin. He should explain to the patient the UGDP controversy and make a clear nota-

tion of the details on his office chart. A signed "informed consent" is not recommended or required at this time.

4. He should not prescribe oral hypoglycemic drugs during pregnancy, whether the patient refuses insulin or not.

5. He should explain the risks of heart and vascular disease to the diabetic — as well as the other complications and concomitants of diabetes, and emphasize the need for patient-responsibility for day-to-day diabetes self-management, especially diet.

6. He should try to educate his diabetic patient to all aspects of diabetes control, but especially to the survival knowledge, preventive information, and pragmatic facts which he requires to stay as healthy as possible.

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⁵Moss J M: The UGDP scandal and cover-up. Letter to the Editor. *JAMA* 232:806-808, May 26, 1975.

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A. Krosnick, M.D.

CLINICAL NOTES

Liability of the Anesthesiologist for Misuse of Anesthesia by Operating Room Personnel

Jan John Ort, M.D./Clifton

The Damocles sword of malpractice is a permanent nightmare in our work. As if that is not enough, the problems of drug abuse have recently infiltrated our medical field as well. We wish to bring to the attention of practicing anesthesiologists a case report of misuse of anesthesia by a hospital employee. In this instance, the anesthesiologist was accused of negligence.

Case Report

A 21-year-old male operating room orderly of South American extraction was assigned to clean anesthesia machines and equipment and to change masks and tubing between cases. Socially, he was known to attend parties of adolescents; often, after weekends he complained of gastric pains and headaches. The possibility of drug abuse was not recognized, despite the fact that he also talked to anesthesiologists about the use of different anesthetics.

One day, after completion of the work schedule, he was found semiconscious in one of the operating rooms, lying over an anesthesia machine and breathing from a mask a mixture of 14 liters nitrous oxide and 2 percent methoxyfluorane. When he awakened, he insisted that the anesthesiologist did not close the flowmeters and that he inhaled the gases while cleaning the machine. This was the last thing he remembered. He was reassigned to work in another department.

Discussion:

Situations where anesthesiologists may be held liable for the adverse effects of anesthetic gases, vapors, or medications on persons other than

patients, who are either willfully misusing them or accidentally exposed to them, are becoming more frequent. These problems range from the most serious, involving death, attempted or successful suicide or murder, to the danger to operating room personnel of chronic exposure to small amounts of anesthetic gases. The misuse of anesthetics by drug abusers falls somewhere between the two categories. There is a well-known case of a physician-succinylcholine-murderer and another where a physician and a nurse injected each other with sodium pentothal, with the physician alone surviving. Fortunately, our case was found before hypoxia ensued and before he could fall and injure himself.

Steps have already been taken to prevent these accidents. Syringes and needles must be counted and destroyed. Exhaust systems are helping to prevent the adverse effects of chronic exposure to anesthetic gases. Sodium thiopental is labeled as a habit-forming drug, but provisions must be made to dispose of the diluted solutions not used within 24 hours.

For drug users, inhalation of anesthetic mixtures is an inexpensive and readily available way to distract themselves from reality. For us, it presents the dilemma of how to prevent this misuse and, at the same time, have the machines ready in case of emergency. In the extreme case, all machines would have to be stored in a locked area, or, at least, the vaporizers would have to be emptied and the central supply of nitrous oxide and oxygen would be closed at the end of each day. Careful supervision of all operating room and delivery room personnel at all times is a necessity. Special attention is needed where nitrous oxide and methoxyfluorane are available for self-administration to patients in labor.

With our knowledge of these problems, it is hoped that they will not occur frequently and that there will be no "anesthesia parties" in any hospital.

**June 4-8, 1976
MSNJ Annual Meeting**

ANNOUNCEMENTS

Programs on Dermatology

The New Jersey Dermatological Society has announced the following program schedule for 1975-1976:

- | | |
|-------------|--|
| November 11 | Case Presentations and Discussion
Charles DeFeo, M.D.
NYU School of Medicine |
| January 13 | Photosensitivity Diseases
Leonard Harber, M.D.
Columbia University College of Physicians
and Surgeons |
| February 10 | Pseudo Tumors — 1976 Update
A. Bernard Ackerman, M.D.
NYU School of Medicine |
| March 9 | Collagen Diseases and Vasculitis
Irwin M. Braverman, M.D.
Yale University School of Medicine |
| April 13 | Clinical Pathological Conference
Lewis Shapiro, M.D.
Columbia University College of Physicians
and Surgeons |
| May 11 | Dinner Meeting
(details to be announced later) |

The meetings are held at 8 p.m. on the dates indicated — in November at the St. Barnabas Medical Center in Livingston; in January, February, and March at Schering Corporation in Kenilworth; and in April at Johnson and Johnson in New Brunswick. For details please communicate with the Secretary of the New Jersey Dermatological Society, Robert M. Fischbein, M.D., 512 East Broad Street, Westfield 07090.

Pulmonary Disease Series

Following is a list of the monthly lectures in pulmonary diseases to be sponsored jointly by the Veterans Administration Hospital in East Orange and the New Jersey Medical School in Newark:

- | | |
|----------|--|
| Nov. 19— | Heterogeneity of ACTH: Relevance to
Physiologic and Pulmonary Disease |
| Dec. 17— | Mechanisms of Lung Injury in Obstructive Lung
Disease |
| Jan. 21— | Interstitial Disease of the Lung |

- | | |
|----------|---|
| Feb. 18— | Protease Inhibitors and Pulmonary Disease |
| Mar. 17— | Pulmonary Cardiogenesis |
| Apr. 21— | Categories of Pulmonary Disease Measured by
Functional and Laboratory Data |
| May 12— | Rehabilitation of Chronic Pulmonary Patient |

All sessions will be held at 11:30 a.m. in the third-floor auditorium of the East Orange Veterans Administration Hospital. For additional information, please communicate with L. Fred Ayvazian, M.D., Chief of the Pulmonary Disease Section at the hospital.

Course in Early Detection of Breast Cancer

The Albert Einstein Medical Center (Northern Division, York and Tabor Roads, Philadelphia) is offering a short-term intensive training course in the modalities of mammography and thermography for early detection of breast cancer. The program, which consists of weekly courses from November 1975 through August 1976 is designed for radiologists and residents in radiology, as well as technologists. Funding is through the National Cancer Institute in coordination with the American College of Radiology. There is no fee and approval has been given for hour-for-hour credit in AMA Category I. For information, please communicate with the project coordinator, Warren Becker, M.D., at the Medical Center — telephone (215) 455-8400.

Surgical Lectures — Rutgers Medical School

The Rutgers Medical School, CMDNJ, Department of Surgery, is sponsoring the following series of lectures, which have been approved for one credit-hour each in Category I of the AMA Physician's Recognition Award:

- | | |
|------------|---|
| December 2 | <i>Use of Vasopressin in Upper Gastrointestinal Hemorrhage</i>
Edward H. Storer, M.D., Professor of
Surgery
Yale University School of Medicine |
| January 6 | <i>Renovascular Hypertension</i>
William J. Fry, M.D., Professor of Surgery
University of Michigan Medical School |

All lectures will be held at 5 p.m. in the main auditorium of Rutgers Medical School, University Heights, Piscataway. For further information please communicate with John H. Landor, M.D., Professor and Chief of the Division of General Surgery at the College.

Course in Emergency Medicine

The New Jersey Medical School, CMDNJ, announces a course in emergency medicine to be held on December 3, 4, and 5, 1975, and again on February 24, 26, and 27, 1976. The sessions will consist of lectures, panel discussions, and demonstrations, and will be presented from 9 a.m. to 4 p.m. each day in the third-floor auditorium of the nurses' residence of the Martland Hospital Unit, CMDNJ. There is no tuition but a \$10 charge is made to cover the cost of three luncheons. Attendance will be awarded with sixteen credit hours in AMA category I. William Grant, M.D., Professor of Ophthalmology, is program director for the course. For registration and additional information, please communicate with him — 100 Bergen Street, Newark 07103, or telephone (201) 456-4658.

Graduate Course in Ischemic Heart Disease

The American College of Chest Physicians will sponsor a postgraduate course in cardiovascular and pulmonary function in ischemic heart disease from December 3 to 5 in San Juan, Puerto Rico. Cosponsors are the University of Puerto Rico School of Medicine, the Veterans Administration Hospital of San Juan, and the San Juan chapter of the College. Formal presentations will be made, followed by group panel discussions. The course is designed to encourage free exchange of information on the problems of daily practice and is structured to meet the needs of the specialist, internist, and generalist. The program is acceptable for 12 credit hours in AMA Category I. Tuition for members is \$125; for non-members, \$150; and for residents, nurses, and therapists, \$75. For further information, please communicate with Mr. Dale E. Braddy, Director of Continuing Education,

American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

Pediatric Arthritis Clinics

Under the auspices of the Greater Delaware Valley Regional Medical Program, demonstration clinics in pediatric arthritis will be conducted by the staff of the connective tissue clinic at the Children's Seashore House in Atlantic City from 9:45 to 11:45 a.m. on the dates listed:

December 17	Differential Diagnosis of Arthritis
February 18	Treatment of Arthritis
April 21	Arthritis in Children

Prior registration is required and admittance is limited to six physicians at each session. Two hours of AMA Category I accreditation will be awarded to those in attendance. Please call or write to B. H. Athreya, M.D., Children's Seashore House, 4111 Atlantic Avenue, Atlantic City 08401 — (609) 345-5191 — for information.

International Academy of Pathology Annual Meeting

From March 23 through March 27, the annual meeting of the International Academy of Pathology will be held in Boston; headquarters hotel is the Sheraton-Boston. Presented will be 80 scientific papers, specialty conferences, a seminar on carcinoma of the breast, 47 short courses, and three special courses — Immunofluorescence in Diagnostic Pathology, Electron Microscopy, and Inflammatory and Neoplastic Disease of the Gastrointestinal Tract. The annual Maude Abbott lecture, "Melanoma: Its Histogenesis and Spontaneous Regression," will be delivered on the 24th by Dr. V. J. McGovern, Director of the Fairfax Institute of Pathology in Camperdown, Australia. Additional information may be obtained from Dr. Leland D. Stoddard, Department of Pathology, Medical College of Georgia, Augusta, Georgia 30902. Information about the courses offered is available from Mrs. J. Preston, IAP Registrar, Armed Forces Institute of Pathology, Room 4090, Washington, D.C. 20306. Reservations for non-members of the Academy must be made by early January.

Programs Leading to Master of Public Health Degree

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley has announced the following graduate programs for pediatricians, obstetricians, and other physicians interested in receiving training in the field of maternal and child health. The programs lead to the degree of Master of Public Health, and tax-exempt fellowship support is available.

Maternal and Child Health: a 9-month program in planning and operating health services for mothers and children

Family Planning: a 9-month academic program in family

planning for maternal and child health specialists

School Health: a 9-month academic program in school health for maternal and child health specialists

Multiply Handicapped and Mentally Retarded Children: a 21-month academic and clinical program in planning and operating community services for these children

Career Development: a 3-year academic and residency program — one year of academic training leading to the degree of Master of Public Health, combined with residency training in pediatrics or obstetrics/gynecology.

Applications are being accepted for the group entering in July or September of 1976. Please write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720, for information.

LETTERS TO THE JOURNAL

Family Practice Residencies

October 3, 1975

Dear Dr. Krosnick:

The article "Primary Care — A Pluralistic Approach" by Dr. Richard Rapkin *JMSNJ* 72: 745-747 (September 1975) is an interesting and sensible discussion of a hotly debated and emotionally charged issue. In general, I agree with his conclusion that until we have tested the effectiveness of a number of systems, we will have no way of knowing which best meets our educational and service delivery needs.

There are, however, a number of issues within the article with which I wish to take exception. In discussing Family Practice Residency Programs, Dr. Rapkin states that they do not allow "exposure to 'state of the art' care in each specialty so that the trainee learns how to use referral services and to know his own limitations." As the residency programs in Family Practice are currently structured in the United States, the trainees receive approximately 50 percent of their training in the traditional in-hospital setting under the supervision of the

various specialty departments. The AMA essentials for an approved residency program in Family Practice clearly point to the need for this type of training for the Family Practice resident.

Dr. Rapkin goes on to state that "in a family practice residency, one's teachers are largely the primary care practitioners of the past, whose knowledge of current medical practice may be limited." I would like to suggest that in terms of teaching in the family practice centers (that is, the ambulatory care portion of the resident's training), the contribution of experienced family practitioners is not only necessary but highly desirable. One of the attractions of family practice residency programs to students has been that the teachers in the Family Practice Center are often the community's most skilled family practitioners. Hopefully all of those who contribute to the education of the future family practitioner (specialist and generalist alike) will continually upgrade their "knowledge" of current medical practice.

If any of your readers are interested in the structure and content of family practice residency programs, I would suggest that they write directly to me at the Department of Family Medicine, CMDNJ — Rutgers Medical School, P.O. Box 101, Piscataway, New Jersey, or to the American Academy of Family Physicians, 1740 West 92nd Street, Kansas City, Missouri.

(signed) Frank C. Snope, M.D.

Medicolegal References

September 15, 1975

Dear Doctor Krosnick:

Over the past ten years the changes and decisions in the legal aspects of medicine prompt every physician, regardless of his specialty, to update his knowledge or become aware of legal medicine.

With the increasing confrontation between physician and patient, and between physician and government, there can be no excuse by any physician for his lack of knowledge of the legal problems he must face in practicing medicine. Just as he must read his medical journals and attend courses for continuing medical credit, so must he begin to read or increase his reading of medicolegal problems that have occurred and their solution.

To this end, a review of medicolegal papers over the past ten years has been made. Fortunately, with the exception of the medicolegal conferences that have been held during the past few years, necessitating travel and expense, many of the papers on the subject have been published in *JAMA*. Physicians desiring a complete list of

these 114 papers may write to Jack R. Karel, M.D., Inter-Agency Commission on Emergency Medical Care, P.O. Box 904, Trenton, New Jersey 08605.

(Signed) Jack R. Karel, M.D.

Bargain of Yesteryear

September 2, 1975

Dear Doctor Krosnick:

I have received a considerable amount of favorable comment concerning the little article you put in the recent *Journal* (editorial, "Society Dues and Medical Complexities," 72: 653, August 1975) and I wish to thank you for the interesting and excellent manner in which, by your editorial expertise, you converted a few scraps of paper into a delightful vignette.

Parenthetically, I also have one of my uncle's copies of the *American Journal of Surgery*, and the subscription rate was \$1.00 per annum. I am in no way implying that the *State Journal* should attempt to meet those rates.

(signed) Richard L. Franklin, M.D.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Nov.

— Every Weekday Conferences

12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice Residency Program and AAFP)

12 Monthly Neuro-Radiology Meetings

7:45 p.m.-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)

12 Anesthesia Conferences

8-9:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)

12 Upper Endoscopy

1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)

12 Medical Lecture Series

19 9-11 a.m. — Riverview Hospital, Red Bank
26 (Sponsored by Riverview Hospital and Academy of Medicine)

12 Review of Internal Medicine

26 Sheraton Inn, Newark Airport, Elizabeth
(Sponsored by Academy of Medicine and CMDNJ — New Jersey Medical School)

- 12 **Current Topics in Psychiatry**
19 3 p.m. — Fair Oaks Hospital, Summit
26 (*Sponsored by Fair Oaks Hospital and Academy of Medicine*)
- 12 **Carcinoma of the Prostate**
1 p.m. — VA Hospital, Lyons
(*Sponsored by VA Hospital and Academy of Medicine*)
- 12 **Cardiac Rehabilitation**
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(*Sponsored by Academy of Medicine*)
- 12 **Annual Scientific Meeting**
8:30 a.m.-5 p.m. — Robert Treat Hotel, Newark
(*Sponsored by New Jersey Academy of Ophthalmology and Otolaryngology and Academy of Medicine*)
- 12 **Ballistics and Missile Wounds**
7:45 p.m. — 198 Clairmont Terrace, Orange
(*Sponsored by Journal Club of Greater Newark and Academy of Medicine*)
- 12 **Dementias Encountered in Medical Practice**
19 **Psychiatric Disorders in Late Life**
26 **Stroke; Warning Signs and Prevention**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(*Sponsored by Middlesex General Hospital and Academy of Medicine*)
- 12 **Review of Internal Medicine**
26 9 a.m.-5 p.m. — Sheraton Inn, Newark Airport, Elizabeth
(*Sponsored by Academy of Medicine, CMDNJ-New Jersey Medical School, and AAFP*)
- 12 **Perinatal Seminars**
19 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
26 (*Sponsored by Newark Beth Israel Medical Center and Academy of Medicine*)
- 12 **Conferences in Endocrinology**
19 3:30-5 p.m. — Location to be announced
26 (*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, Newark Beth Israel Medical Center, and Academy of Medicine*)
- 12 **Continuing Medical Education Program**
19 10:30-11:30 a.m. — Clara Maass Hospital, Belleville
26 (*Sponsored by Clara Maass Hospital and AAFP*)
- 12 **Advances in Medicine**
19 9:30 a.m. — Bergen Pines County Hospital, Paramus
26 (*Sponsored by Bergen Pines County Hospital and Academy of Medicine*)
- 13 **Advances in Immunology**
20 4-6 p.m. — Institute for Medical Research, Camden
(*Sponsored by Institute for Medical Research and AAFP*)
- 13 **Radiology Diagnosis**
6:30 p.m. — Bridgeton Hospital, Bridgeton
(*Sponsored by Bridgeton Hospital*)
- 13 **Diabetes**
11 a.m. — John F. Kennedy Medical Center, Edison
(*Sponsored by Academy of Medicine*)
- 13 **Diagnostic Ultrasound in Obstetrics**
7:30 p.m. — East Orange General Hospital
(*Sponsored by New Jersey Institute of Ultrasound in Medicine and Academy of Medicine*)
- 13 **Advances in Immunology Course**
20 4-6 p.m. — Institute for Medical Research, Camden
(*Sponsored by Institute for Medical Research and Academy of Medicine*)
- 13 **Techniques and Capabilities of Radiology Diagnosis**
6:30 p.m. — Bridgeton
(*Sponsored by Bridgeton Hospital*)
- 14 **Monthly Scientific Meeting**
8:30 p.m. — Hackensack Hospital
(*Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine*)
- 14 **Continuing Medical Education Program**
7:45 a.m. — West Jersey Hospital, Voorhees
(*Sponsored by West Jersey Hospital, University of Pennsylvania School of Medicine, and AAFP*)
- 14 **Psychiatric Lecture Series**
21 1:30-5 p.m. — Trenton Psychiatric Hospital
(*Sponsored by Trenton Psychiatric Hospital and Academy of Medicine*)
- 14 **Family Practice Seminars**
21 12:30 p.m. — Overlook Hospital, Summit
28 (*Sponsored by Overlook Hospital and AAFP*)
- 15 **Advances in Orthopedic Surgery**
22 8:30-11:30 a.m. — CMDNJ, New Jersey Medical School, Newark
29 (*Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine*)
- 15 **Diabetes Mellitus Symposium**
9:30 a.m.-3:15 p.m., — Newark Beth Israel Medical Center
(*Sponsored by American Diabetes Association (New Jersey Affiliate) and Academy of Medicine of N.J.*)
- 15 **Advances in Gastrointestinal Disorders**
Saint Barnabas Medical Center, Livingston
(*Sponsored by Saint Barnabas Medical Center and AAFP*)
- 17 **Gallstones: A Medical Disease**
12 noon-1 p.m. — Montclair Community Hospital
(*Sponsored by Montclair Community Hospital and Academy of Medicine of New Jersey*)
- 17 **Portal Hypertension**
7:45-9 a.m. — Newark Beth Israel Medical Center
(*Sponsored by Newark Beth Israel Medical Center and Academy of Medicine*)
- 17 **Diagnostic Radiographic Examination**
8-9 p.m. — 987 Sanford Avenue, Irvington
(*Sponsored by New Jersey Medical Women's Association (Essex County Chapter) and Academy of Medicine*)
- 17 **Distinguished Lectures in Surgery**
24 4-5 p.m. — Martland Hospital Unit, Newark
(*Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine*)

- 17 **Pediatric Happenings**
 - 24 12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital, and AAFP)
 - 18 **Electrosurgical Hazards in the O.R.**
8 p.m. — Ramada Inn, Clark
(Sponsored by New Jersey State Society of Anesthesiologists and Academy of Medicine)
 - 18 **Ultrasound as a Noninvasive Diagnostic Procedure**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital, and Academy of Medicine)
 - 18 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
 - 18 **Topics in Neurosurgery**
 - 25 4-5 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
 - 18 **Psychiatric Case Conferences**
 - 25 7:30-9:30 a.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 18 **Survey of Allergy-Immunology**
 - 25 11 a.m. — St. Elizabeth Hospital, Elizabeth
(Sponsored by Elizabeth Tri-Hospital Residency Program and AAFP)
 - 18 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
 - 19 **Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital and Academy of Medicine)
 - 19 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
 - 19 **Family Practice Multidiscipline Conference**
12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
 - 19 **Cardiology Conferences**
4-5:30 p.m. — CMDNJ, Rutgers Medical School, Piscataway
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)
 - 19 **Neurology**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 19 **Pre-hospital Coronary Care**
2 p.m. — Cherry Hill Medical Center
(Sponsored by Cherry Hill Medical Center and Academy of Medicine)
 - 19 **Marriage and the Family**
9 a.m.-5 p.m. — Camden County Hospitals, Lakeland
(Sponsored by Camden County Hospitals and Academy of Medicine)
 - 19 **Proper Use of Antibiotics**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
 - 19 **Human Sexuality and the Medical Profession**
1 p.m. — Cooper Medical Center Clinic, Camden
(Sponsored by Planned Parenthood — Greater Camden Area and Academy of Medicine)
 - 20 **Abdominal Aortic Aneurysm and other Peripheral Aneurysms**
12 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
 - 20 **Percutaneous Removal of Biliary Calculi**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
 - 20 **Continuing Medical Education Programs**
11 a.m. — John F. Kennedy Medical Center, Edison
(Sponsored by John F. Kennedy Medical Center and Academy of Medicine)
 - 21 **Current Treatment of Burns**
12 Noon — Freehold Area Hospital
(Sponsored by Academy of Medicine of New Jersey)
 - 21 **Gastrointestinal Bleeding**
12 Noon — Montclair Community Hospital
(Sponsored by Academy of Medicine of New Jersey)
 - 25 **Inflammatory Bowel Disease**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
 - 25 **Medical-Legal Aspects of Medicine and Surgery**
12 Noon — Hospital Center at Orange
(Sponsored by Academy of Medicine of New Jersey)
 - 25 **Family Practice/Psychiatric Case Presentations**
12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
 - 25 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 26 **Diagnosis of Pelvic Disease — Office Gynecology**
6:30 p.m. — Bridgeton Hospital
(Sponsored by Bridgeton Hospital)
- Dec.
- **Every Weekday Conferences**
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice Residency Program and AAFP)

- 1 **Proper Use of Blood Gases**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
- 1 **Pediatric Happenings**
8 12:30 p.m. — Overlook Hospital, Summit
15 (Sponsored by Overlook Hospital, and AAFP)
22
29
- 1 **Distinguished Lectures in Surgery**
8 4-5 p.m. — Martland Hospital Unit, Newark
15 (Sponsored by CMDNJ-New Jersey Medical School
22 and Academy of Medicine)
29
- 2 **Clinical Endocrinology**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
- 2 **Emergencies Seen in the Ambulatory Setting**
11 a.m.-12 noon — Overlook Hospital, Summit
(Sponsored by Departments of Family Practice and Community Medicine and AAFP)
- 2 **Psychiatric Case Conferences**
9 7:30 a.m. — Trenton Psychiatric Hospital
16 (Sponsored by Trenton Psychiatric Hospital
23 and Academy of Medicine)
30
- 2 **Topics in Neurosurgery**
9 4-5 p.m. — VA Hospital, East Orange
16 (Sponsored by CMDNJ-New Jersey Medical School,
23 VA Hospital, and Academy of Medicine)
30
- 2 **Family Practice/Psychiatric Case Presentations**
23 12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 2 **Survey of Allergy-Immunology**
9 11 a.m. — St. Elizabeth Hospital, Elizabeth
16 (Sponsored by Elizabeth Tri-Hospital Residency
Program and AAFP)
- 3 **Office Medical Record**
Somerset Hospital, Somerville
(Sponsored by CMDNJ-Rutgers Medical School and AAFP)
- 3 **Review of Internal Medicine**
10 Sheraton Inn, Newark Airport, Elizabeth
(Sponsored by Academy of Medicine and CMDNJ-New Jersey Medical School)
- 3 **Pathology as it Relates to Medical Conditions**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 3 **Medical Lecture Series**
10 9-11 a.m. — Riverview Hospital, Red Bank
17 (Sponsored by Riverview Hospital and Academy of Medicine)
- 3 **Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 3 **Psychiatric Aspects of Criminology**
17 Part I and Part II
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 3 **Advances in Medicine**
10 9:30 a.m. — Bergen Pines County Hospital, Paramus
17 (Sponsored by Bergen Pines County Hospital and Academy of Medicine)
24
- 3 **Perinatal Seminars**
10 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
17 (Sponsored by Newark Beth Israel Medical Center and Academy of Medicine)
- 3 **Conferences in Endocrinology**
10 3:30-5 p.m. — Location to be announced
17 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, Newark Beth Israel Medical Center, and Academy of Medicine)
- 3 **Current Topics in Psychiatry**
10 3 p.m. — Fair Oaks Hospital, Summit
17 (Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 3-5 **Emergency Medicine Conferences**
9-4 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 3 **Cardiology Conferences**
17 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)
- 3 **Family Practice Multidiscipline Conference**
17 12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 3 **Continuing Medical Education Program**
10:30-11:30 a.m. — Clara Maass Hospital, Belleville
(Sponsored by Clara Maass Hospital and AAFP)
- 3 **Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 3 **Diagnosis of the Anemic Patient**
1 p.m. — VA Hospital, Lyons
(Sponsored by VA Hospital and Academy of Medicine)
- 3 **Medicolegal Seminar**
9 a.m.-5 p.m. — Cherry Hill Inn, Cherry Hill
(Sponsored by Inter-Agency Commission on Emergency Medical Care and Academy of Medicine)
- 3 **Monthly Meeting**
8-10 p.m. — Mountainside Hospital, Montclair
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)
- 3 **Can You Treat Depression?**
10 **Application of Acupuncture in Medical Practice**
Recent Trends in Genetics
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

- 4 **Advances in Immunology**
11 4-6 p.m. — Institute for Medical Research, Camden
18 (*Sponsored by Institute for Medical Research and AAFP*)
- 4 **Continuing Medical Education Programs**
18 11 a.m. — John F. Kennedy Medical Center, Edison
(*Sponsored by John F. Kennedy Medical Center and Academy of Medicine*)
- 5 **Family Practice Seminars**
12 12:30 p.m. — Overlook Hospital, Summit
19 (*Sponsored by Overlook Hospital and AAFP*)
- 5 **Chronic Renal Failure**
8:30 a.m. — United Hospitals of Newark
(*Sponsored by United Hospitals of Newark and Academy of Medicine*)
- 5 **Positive Nitro-Blue Tetrazolium Test and Protein Changes in Serum**
12 noon — St. Mary's Hospital, Orange
(*Sponsored by St. Mary's Hospital and Academy of Medicine*)
- 6 **Advances in Orthopedic Surgery**
13 8:30-11:30 a.m. — CMDNJ, New Jersey Medical
20 School, Newark
27 (*Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine*)
- 9 **Allergy**
8 p.m. — Paul Kimball Hospital, Lakewood
(*Sponsored by Paul Kimball Hospital and Academy of Medicine*)
- 9 **Breast Cancer**
9 p.m. — Bayonne Hospital
(*Sponsored by Bayonne Hospital and Academy of Medicine*)
- 9 **Breast Cancer**
9 p.m. — West Hudson Hospital, Kearny
(*Sponsored by West Hudson Hospital and Academy of Medicine*)
- 9 **Problems of Medication During Pregnancy**
8:30 p.m. — 361 Roseville Avenue, Newark
(*Sponsored by Journal Club of Greater Newark and Academy of Medicine*)
- 10 **Hypertension**
11:30 a.m. — Mercer Medical Center, Trenton
(*Sponsored by Mercer Medical Center and Academy of Medicine*)
- 10 **Monthly Neuro-Radiology Meetings**
7:45-10:15 p.m. — Morristown Memorial Hospital
(*Sponsored by Radiological Society of New Jersey and Academy of Medicine*)
- 10 **Anesthesia Conferences**
8-9:30 p.m. — West Jersey Hospital, Voorhees
(*Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine*)
- 11 **Management of Venereal Diseases**
6:30 p.m. — Bridgeton Hospital, Bridgeton
(*Sponsored by Bridgeton Hospital*)
- 11 **Coronary Bypass Surgery**
11 a.m. — John F. Kennedy Medical Center, Edison
(*Sponsored by John F. Kennedy Medical Center and Academy of Medicine*)
- 12 **Monthly Scientific Meeting**
8:30 p.m. — Hackensack Hospital
(*Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine*)
- 13 **Seminary on Antimicrobial Therapy**
8 a.m.-5 p.m. — Holiday Inn, Jersey City
(*Sponsored by Hudson County Medical Society and Academy of Medicine*)
- 15 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(*Sponsored by Pascack Valley Hospital and Academy of Medicine*)
- 15 **Clinical Aspects of Colonic Cancer**
12 noon-1 p.m., Montclair Community Hospital
(*Sponsored by Montclair Community Hospital and Academy of Medicine*)
- 16 **Sports Medicine**
11:30 a.m. — St. Mary's Hospital, Orange
(*Sponsored by St. Mary's Hospital and Academy of Medicine*)
- 16 **Chondromalacia**
5 p.m. — St. Mary's Hospital, Orange
(*Sponsored by St. Mary's Hospital and Academy of Medicine*)
- 16 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine*)
- 17 **Cardiopulmonary Resuscitation**
2:30 p.m., Trenton Psychiatric Hospital
(*Sponsored by Trenton Psychiatric Hospital and Academy of Medicine*)
- 17 **Acute Abdominal Trauma and Peritoneal Lavage as Diagnostic Tool**
1 p.m. — Christ Hospital, Jersey City
(*Sponsored by Christ Hospital and AAFP*)
- 17 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine*)
- 17 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine*)
- 17 **Recognition and Treatment of Hemorrhagic Disorders in the Surgical Patient**
7 p.m. — Englewood Men's Club
(*Sponsored by Englewood Surgical Society and Academy of Medicine*)
- 19 **Coronary Heart Disease**
12 noon — Montclair Community Hospital
(*Sponsored by Montclair Community Hospital and Academy of Medicine*)

- 30 Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)

Jan.

- **Every Weekday Conferences**
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice Residency Program and AAFP)

- 3 Advances in Orthopedic Surgery**
10 8:30-11:30 a.m. — CMDNJ, New Jersey Medical
17 School, Newark
24 (Sponsored by CMDNJ-New Jersey Medical School
31 and Academy of Medicine)

- 5 Headache**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)

- 5 Neonatal Emergencies**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)

- 5 Distinguished Lectures in Surgery**
12 4-5 p.m. — Martland Hospital Unit, Newark
19 (Sponsored by CMDNJ-New Jersey Medical School
26 and Academy of Medicine)

- 5 Pediatric Happenings**
12 12:30 p.m. — Overlook Hospital, Summit
19 (Sponsored by Overlook Hospital and AAFP)
26

- 6 Diabetes**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)

- 6 Recognition and Management of Depressive State**
12 noon — Hospital Center at Orange
(Sponsored by Hospital Center at Orange and Academy of Medicine)

- 6 Family Practice/Psychiatric Case Presentations**
12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)

- 6 Psychiatric Case Conferences**
13 7:30 p.m. — Trenton Psychiatric Hospital
20 (Sponsored by Trenton Psychiatric Hospital and
27 Academy of Medicine)

- 6 Topics in Neurosurgery**
13 4-5 p.m. — VA Hospital, East Orange
20 (Sponsored by CMDNJ-New Jersey Medical School,
27 VA Hospital, and Academy of Medicine)

- 7 Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by Academy of Medicine and CMDNJ — New Jersey Medical School)

- 7 Management of Hepatitis**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)

- 7 Hypertension**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)

- 7 Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)

- 7 Perinatal Seminars**
14 9:30 a.m.-2 p.m. — Newark Beth Israel Medical
21 Center
28 (Sponsored by Newark Beth Israel Medical Center and Academy of Medicine)

- 7 Conferences in Endocrinology**
14 3:30-5 p.m. — Location to be announced
21 (Sponsored by CMDNJ-New Jersey Medical School,
28 VA Hospital, East Orange, Newark Beth Israel Medical Center and Academy of Medicine)

- 7 Cardiology Conferences**
21 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School, Academy of Medicine of N.J.)

- 7 Clinical Applications of Liver Physiology**
14 **Respiratory Failure**
21 **Recognition and Management of Heart Failure**
28 **Fluid and Electrolyte Problems in Pediatric Practice**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

- 7 Medical Lecture Series**
14 9-11 a.m. — Riverview Hospital, Red Bank
21 (Sponsored by Riverview Hospital and
28 Academy of Medicine)

- 8 Advances in Immunology Course**
15 4-6 p.m. — Institute for Medical Research, Camden
22 (Sponsored by Institute for Medical Research and
29 Academy of Medicine)

- 9 Family Practice Seminars**
16 12:30 p.m. — Overlook Hospital, Summit
23 (Sponsored by Overlook Hospital and AAFP)
30

- 9 Renal Symposium**
9 a.m.-5 p.m. — CMDNJ, New Jersey Medical School, Newark
(Sponsored by CMDNJ-New Jersey Medical School, N.J. RMP, Ruth Gottsche Kidney Foundation, Nephrology Society of New Jersey and Academy of Medicine)

- 9 Monthly Scientific Meeting**
8:30 p.m. — Hackensack Hospital
(Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine)

- 9 Obstructive Lung Disease**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)

- 13 **Photosensitivity Diseases**
8 p.m. — Schering Corporation, Kenilworth
(Sponsored by Academy of Medicine and New Jersey Dermatological Society)
 - 13 **Thyroid Diseases**
10 a.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of Medicine)
 - 13 **Infectious Diseases**
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)
 - 13 **Proper Use of Antibiotics**
9 p.m. — West Hudson Hospital, Kearny
(Sponsored by West Hudson Hospital and Academy of Medicine)
 - 14 **Anesthesia Conference**
8-9:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
 - 14 **Monthly Neuro-Radiology Meetings**
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)
 - 14 **Gastrointestinal Bleeding**
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by John E. Runnells Hospital and Academy of Medicine)
 - 14 **Diagnosis and Monitoring of Shock**
 - 21 **Mitral Valve Disease**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 14 **Family Practice Multidiscipline Conference**
 - 28 **12:30 p.m. — Overlook Hospital, Summit**
(Sponsored by Overlook Hospital, and AAFP)
 - 16 **Medical Management of the Complications of Pregnancy**
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
 - 19 **Medical Lecture Series**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 20 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
 - 20 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital and Academy of Medicine)
 - 20 **Cardiac Rehabilitation**
11:30 a.m., St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
 - 20 **Acupuncture**
8 p.m. — Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)
 - 21 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
 - 21 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital and Academy of Medicine)
 - 21 **Proper Use of Endoscopy**
1 p.m. — VA Hospital, Lyons
(Sponsored by VA Hospital and Academy of Medicine)
 - 21 **Psychiatry-Group Therapy**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 21 **Proper Use of Blood Gases**
2 p.m. — Cherry Hill Medical Center
(Sponsored by Cherry Hill Medical Center and Academy of Medicine)
 - 22 **Pulmonary Sarcoidosis**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
 - 26 **Neonatal Emergencies**
11:30 a.m., Helene Fuld Hospital, Trenton
(Sponsored by Helene Fuld Hospital and Academy of Medicine)
 - 27 **Medical-Legal Aspects of Medicine and Surgery**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
 - 27 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 28 **Echocardiography in Assessment of Patient with Coronary Artery Disease**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 30 **Proper Use of Endoscopy**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- Feb.
- 2 **Diagnosis of the Anemic Patient**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
 - 2 **Cerebral Vascular Disease**
1 p.m. — Ancora Psychiatric Hospital
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)

- 2 Pediatric Happenings**
9 12:30 p.m. — Overlook Hospital, Summit
16 *(Sponsored by Overlook Hospital and AAFP)*
23
- 2 Distinguished Lectures in Surgery**
9 4-5 p.m. — Martland Hospital Unit, Newark
16 *(Sponsored by CMDNJ-New Jersey Medical School*
23 *and Academy of Medicine)*
- 3 Family Practice/Psychiatric Case Presentations**
 12:30 p.m., Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 3 Laboratory Interpretations**
 11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital
and Academy of Medicine)
- 3 Psychiatric Case Conferences**
10 7:30 a.m. — Trenton Psychiatric Hospital
17 *(Sponsored by Trenton Psychiatric Hospital*
24 *and Academy of Medicine)*
- 3 Topics in Neurosurgery**
10 4-5 p.m. — VA Hospital, East Orange
17 *(Sponsored by CMDNJ-New Jersey Medical School,*
24 *VA Hospital and Academy of Medicine)*
- 4 Laboratory Interpretations**
 1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of
Medicine)
- 4 Malpractice**
 3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of
Medicine)
- 4 Conferences in Endocrinology**
 6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School
and Academy of Medicine)
- 4 Distinguished Lectures in Obstetrics and Gynecology**
 6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School
and Academy of Medicine)
- 4 Medical Lecture Series**
11 9-11 a.m. — Riverview Hospital, Red Bank
18 *(Sponsored by Riverview Hospital and*
25 *Academy of Medicine)*
- 4 Electrolyte Problems in the Aged**
11 Food Faddism and Hypervitaminosis
18 Obesity-Fact and Fantasy
25 Abnormal Uterine Bleeding
 9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and
Academy of Medicine)
- 4 Conferences in Endocrinology**
11 3:30-5 p.m. — Location to be announced
18 *(Sponsored by CMDNJ-New Jersey Medical School,*
25 *VA Hospital, Newark Beth Israel Medical Center, and*
Academy of Medicine)
- 4 Perinatal Seminars**
11 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
18 *(Sponsored by Newark Beth Israel Medical Center and*
25 *Academy of Medicine)*
- 4 Cardiology Conferences**
18 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and
Academy of Medicine)
- 5 Advances in Immunology**
12 4-6 p.m. — Institute for Medical Research, Camden
19 *(Sponsored by Institute for Medical Research*
26 *and AAFP)*
- 6 Malpractice**
 8:30 a.m. — United Hospitals of Newark
(Sponsored by United Hospitals of Newark and
Academy of Medicine)
- 6 Family Practice Seminars**
13 12:30 p.m., Overlook Hospital, Summit
20 *(Sponsored by Overlook Hospital and AAFP)*
27
- 7 Advances in Orthopedic Surgery**
14 8:30-11:30 a.m., CMDNJ, New Jersey Medical School,
21 Newark
28 *(Sponsored by CMDNJ-New Jersey Medical School*
and Academy of Medicine)
- 10 Psuedo-Tumors, 1976 Update**
 8 p.m. — Schering Corporation, Kenilworth
(Sponsored by Academy of Medicine, and New Jersey
Dermatological Society)
- 10 Current Treatment of Burns**
 10 a.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of
Medicine)
- 10 Breast Cancer**
 8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of
Medicine)
- 10 Fluid and Electrolyte Imbalance**
 9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of
Medicine)
- 11 Differential Diagnosis of Arthritis**
 1 p.m. — VA Hospital, Lyons
(Sponsored by VA Hospital and Academy of Medicine)
- 11 Monthly Neuro-Radiology Meetings**
 7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and
Academy of Medicine)
- 11 Peritoneoscopy**
 1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital, Jersey City)
- 11 Anesthesia Conferences**
 8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of
Pennsylvania School of Medicine)

- 11 **Family Practice Multidiscipline Conference**
25 12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 13 **Monthly Scientific Meeting**
8:30 p.m., Hackensack Hospital
(Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine)
- 16 **1975-76 Lecture Series**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 17 **Pacemakers**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital)
- 17 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m., Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
- 17 **Radiology of Genitourinary Disease**
7-9:30 p.m. VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
- 18 **Advances in Management of Tuberculosis**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 18 **Annual Meeting**
7 p.m. — Forsgate Farms Country Club, Jamesburg
(Sponsored by American Diabetes Association, [New Jersey Affiliate] and Academy of Medicine)
- 18 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital and Academy of Medicine)
- 20 **Diabetes**
12 noon, Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
- 24-27 **Emergency Medical Conferences**
9 a.m.-4 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 24 **Proper Use of Endoscopy**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
- 24 **Peripheral Vascular Disease**
11 a.m. — Perth Amboy General Hospital
(Sponsored by Perth Amboy General Hospital and Academy of Medicine)
- 24 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 25 **Dysfunctional Uterine Bleeding**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)
- 25 **Acupuncture**
2 p.m. — Cherry Hill Medical Center
(Sponsored by Cherry Hill Medical Center and Academy of Medicine)
- 26 **Renal Angiography**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
- 27 **Cardiac Arrhythmias**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 28 **Recent Advances in Pulmonary Disease**
11:30 a.m., VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital)
- Mar.
- 1 **Distinguished Lectures in Surgery**
8 4-5 p.m. — Martland Hospital Unit, Newark
15 (Sponsored by CMDNJ-New Jersey Medical School
22 and Academy of Medicine)
29
- 1 **Congestive Heart Failure**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)
- 1 **Medical-Legal Aspects of Medicine and Surgery**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
- 2 **Psychiatric Case Conferences**
9 7:30-9:30 a.m. — Trenton Psychiatric Hospital
16 (Sponsored by Trenton Psychiatric Hospital and
23 Academy of Medicine)
30
- 2 **Topics in Neurosurgery**
9 4-5 p.m. — VA Hospital, East Orange
16 (Sponsored by CMDNJ-New Jersey Medical School,
23 VA Hospital, East Orange, and Academy of Medicine)
30
- 2 **Medical-Legal Aspects of Medicine and Surgery**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
- 3 **Perinatal Seminars**
10 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
17 (Sponsored by Newark Beth Israel Medical Center)
24
31
- 3 **Conferences in Endocrinology**
10 3:30-5 p.m. — Location to be announced
17 (Sponsored by CMDNJ-New Jersey Medical School,
24 VA Hospital, East Orange, Newark Beth Israel
31 Medical Center and Academy of Medicine)

- 3 **Hormones in Office Gynecologic Practice**
- 10 **Risk Factors in Breast Cancer**
- 17 **Breast Problems Encountered in Office Practice**
- 24 **Epidemiology and Host Susceptibility Factors in Cancer**
- 31 **Office Dermatology**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
- 3 **Medical Lecture Series**
- 10 9-11 a.m. — Riverview Hospital, Red Bank
- 17 (Sponsored by Riverview Hospital and
- 24 Academy of Medicine)
- 31
- 3 **Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 3 **Cardiology Conferences**
- 17 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School, Academy of Medicine)
- 3 **Liver, Surgery and Biopsy**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital, Academy of Medicine and AAFP)
- 3 **Conferences in Endocrinology**
6 p.m., Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 4 **Advances in Immunology**
- 11 4-6 p.m. — Institute for Medical Research, Camden
- 18 (Sponsored by Institute for Medical Research
- 25 and AAFP)
- 5 **Fall-Spring Psychiatric Lecture Series**
- 12 1:30-5 p.m. — Trenton Psychiatric Hospital
- 19 (Sponsored by Trenton Psychiatric Hospital and
- 26 Academy of Medicine)
- 5 **Fungal Infections**
8:30 a.m. — United Hospitals of Newark
(Sponsored by United Hospitals of Newark and Academy of Medicine)
- 6 **Advances in Orthopedic Surgery**
- 13 8:30-11:30 a.m., CMDNJ, New Jersey Medical School,
- 20 Newark
- 27 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 9 **New Developments in Scanning**
10 a.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of Medicine)
- 9 **Headache**
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)
- 9 **Thyroid Diseases**
9 p.m. — West Hudson Hospital, Kearny
(Sponsored by West Hudson Hospital and Academy of Medicine)
- 9 **Collagen Diseases and Vasculitis — 1976**
Schering Corporation, Kenilworth
(Sponsored by Academy of Medicine and New Jersey Dermatological Society)
- 10 **Monthly Neuro-Radiology Meetings**
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)
- 10 **Anesthesia Conference**
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
- 10 **Medical-Legal Aspects of Medicine and Surgery**
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by John E. Runnells Hospital and Academy of Medicine)
- 10 **Cerebral Vascular Disease**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 12 **Monthly Scientific Meeting**
8:30 p.m. — Hackensack Hospital
(Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine)
- 15 **Proper Use of Antibiotics**
11:30 a.m. — Helene Fuld Hospital, Trenton
(Sponsored by Helene Fuld Hospital and Academy of Medicine)
- 15 **Medical Lecture Series**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 16 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
- 16 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
- 16 **Arthritis**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
- 16 **Clinical Immunology**
12 noon — Hospital Center at Orange
(Sponsored by Hospital Center at Orange and Academy of Medicine)
- 17 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and VA Hospital, East Orange and Academy of Medicine)
- 17 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)

- 17 **The Right to Psychiatric Treatment**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 19 **Infertility**
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
 - 23 **New Developments in Scanning**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
 - 24 **The Limbic System; Behavior and Epilepsy**
VA Hospital — East Orange
(Sponsored by VA Hospital, East Orange, and Academy of Medicine)
 - 25 **CA of the Lung**
7:15 p.m.-10:15 p.m. — Hospital Center of Orange
(Sponsored by Academy of Medicine and the Radiological Society of New Jersey)
 - 26 **Arthritis**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 27-28 **17th Annual Postgraduate Anesthesia Seminar**
Cherry Hill Inn, Cherry Hill
(Sponsored by New Jersey State Society of Anesthesiologists and Academy of Medicine)
 - 30 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- Apr.
- 2 **Fall-Spring Psychiatric Lecture Series**
 - 9 1:30-5 p.m. — Trenton Psychiatric Hospital
 - 16 (Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 23
 - 2 **Pre-Hospital Coronary Care**
8:30 a.m. — United Hospitals of Newark
(Sponsored by United Hospitals of Newark and Academy of Medicine)
 - 3 **Advances in Orthopedic Surgery**
 - 10 8:30-11:30 a.m. — CMDNJ — New Jersey Medical School, Newark
 - 17
 - 24 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 5 **Distinguished Lectures in Surgery**
 - 12 4-5 p.m. — Martland Hospital Unit, Newark
 - 19 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 26
 - 5 **Medical-Legal Aspects of Medicine and Surgery**
1 a.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)
 - 5 **Current Chemotherapy of Malignant Disease**
8 p.m., Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
 - 6 **Topics in Neurosurgery**
 - 13 4-5:00 p.m., VA Hospital, East Orange
 - 20 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)
 - 27
 - 6 **Psychiatric Case Conferences**
 - 13 7:30 a.m. — Trenton Psychiatric Hospital
 - 20 (Sponsored by Trenton Psychiatric Hospital)
 - 27
 - 6 **Comprehensive Review of Chemotherapy in Psychiatry**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
 - 7 **Perinatal Seminars**
 - 14 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
 - 21 (Sponsored by Newark Beth Israel Medical Center and Academy of Medicine)
 - 28
 - 7 **Pathogenesis and Management of Uremia**
 - 14 **Sensory Feedback in Neurological Disorders**
 - 21 **Basic Principles of Behavior Therapy**
 - 28 **Medical Aspects of the Psychiatric Consultation**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
 - 7 **Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 7 **Conferences in Endocrinology**
 - 14 3:30-5 p.m. — Location to be announced
 - 21 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, Newark Beth Israel Medical Center and Academy of Medicine)
 - 28
 - 7 **Cardiology Conferences**
 - 21 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)
 - 7-9 **Emergency Medicine Conferences (Three Day Sessions)**
9 a.m.- 4 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 7 **Neurology-Headache**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored Christ Hospital, Academy of Medicine, and AAFP)
 - 7 **Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 7 **Monthly Meeting**
8-10 p.m. — Morristown Memorial Hospital
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)

- 9 **Monthly Scientific Meeting**
8:30 p.m. — Hackensack Hospital
(Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine)
 - 13 **Clinical Endocrinology**
8 p.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of Medicine)
 - 13 **Clinical Immunology**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine)
 - 13 **Diabetes**
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)
 - 13 **Clinical Pathological Conference**
8 p.m. — Johnson & Johnson, New Brunswick
(Sponsored by Academy of Medicine and New Jersey Dermatological Society)
 - 14 **Monthly Neuro-Radiology Meetings**
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey)
 - 14 **Anesthesia Conferences**
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
 - 15 **Renal Regulation of Sodium Excretion**
Somerset Hospital, Somerville
(Sponsored by Nephrology Society of New Jersey, N.J. RMP and Academy of Medicine)
 - 16 **Surgical Management of Ulcerative Colitis**
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
 - 17 **Monitoring of the High Risk Patient**
9 a.m. — St. Barnabas Hospital, Livingston
(Sponsored by St. Barnabas Hospital, Department of Surgery)
 - 19 **Medical Lecture Series**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 20 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
 - 20 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
 - 20 **Dermatology**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
 - 21 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
 - 21 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
 - 21 **Treatment of Pain; Medical & Neurosurgical**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 21 **Thyroid Diseases**
3 p.m., Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
 - 21 **Geriatric Psychiatric Syndromes with Review of Chemotherapy**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)
 - 22 **The Middle Ear**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
 - 27 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 27 **Trauma-Outpatient Department**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
 - 30 **Diagnosis of the Anemic Patient**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- May
- 1 **Advances in Orthopedic Surgery**
8 8:30-11:30 a.m. — CMDNJ, New Jersey Medical School, Newark
 - 15 **School, Newark**
22 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 29
 - 10 **Distinguished Lectures in Surgery**
17 4-5 p.m. — Martland Hospital Unit, Newark
 - 24 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 3 **Anesthesiology**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
 - 4 **Topics in Neurosurgery**
11 4-5 p.m., VA Hospital, East Orange
 - 18 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)
 - 25

- 4 **New Developments in Scanning**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
- 4 **Psychiatric Case Conferences**
11 7:30 a.m. — Trenton Psychiatric Hospital
19 (Sponsored by Trenton Psychiatric Hospital)
- 25
- 5 **Renal Tubular Dysfunction**
- 12 **Intestinal Absorption and Malabsorption**
- 19 **The Future of Allergy**
- 26 **Office Use of Antibiotics**
9:00-11:00 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
- 5 **Conferences in Endocrinology**
12 3:30-5 p.m. — Location to be announced
19 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, Newark Beth Israel Medical Center and Academy of Medicine)
- 26
- 5 **Perinatal Seminars**
12 9:30 a.m.-2 p.m., Newark Beth Israel Medical Center
19 (Sponsored by Newark Beth Israel Medical Center)
- 5 **Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 5 **Cardiology Conferences**
19 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)
- 5 **Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 5 **Peripheral Vascular Disease**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital, Jersey City)
- 7 **Fiberoptic Bronchoscopy**
8:30 a.m. — United Hospitals of Newark
(Sponsored by United Hospitals of Newark and Academy of Medicine)
- 11 **Arthritis**
10 a.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of Medicine)
- 11 **Emergency Medicine**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine)
- 11 **Laboratory Interpretations**
9 p.m. — West Hudson Hospital, Kearny
(Sponsored by West Hudson Hospital and Academy of Medicine)
- 11 **Arthritis**
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)
- 12 **Anesthesia Conferences**
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and School of Medicine)
- 12 **Office Treatment of Depression**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 12 **Monthly Neuro-Radiology Meetings**
7:45-10:15 p.m., Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey)
- 12 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School VA Hospital, and Academy of Medicine)
- 12 **Chronic Renal Failure**
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by John E. Runnells Hospital and Academy of Medicine)
- 17 **Medical Lecture Series**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 18 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
- 18 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
- 18 **Headache**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
- 18 **Drug Addiction**
12 noon — Hospital Center at Orange
(Sponsored by Hospital Center at Orange and Academy of Medicine)
- 19 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
- 19 **Diabetes Mellitus**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 19 **New Developments in Scanning**
Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 19-21 **Emergency Medicine Conferences**
9 a.m.-4 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)

20 To be announced
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)

21 Management of Hepatitis
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)

21 Management of End State Renal Disease
2 p.m. — Cherry Hill Medical Center
(Sponsored by Cherry Hill Medical Center and Academy of Medicine)

25 Clinical Pathological Conferences
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)

25 Drug Addiction
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)

26 Annual Awards Dinner
6:30 p.m., The Chanticleer, Millburn
(Sponsored by Academy of Medicine)

26 Child Abuse Revisited
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)

28 Thyroid Diseases
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)

June

1 Psychiatric Case Conferences
8 7:30 a.m. — Trenton Psychiatric Hospital
15 (Sponsored by Trenton Psychiatric Hospital)
22 & 29

1 Topics in Neurosurgery
8 4-5 p.m. — VA Hospital, East Orange
15 (Sponsored by CMDNJ-New Jersey Medical School,
22 VA Hospital, and Academy of Medicine)
29

1 Psychiatric Case Conferences
8 7:30-9:30 a.m. — Trenton Psychiatric Hospital
15 (Sponsored by Trenton Psychiatric Hospital and
22 Academy of Medicine)
29

2 Obstructive Lung Disease
1:00 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)

2 Cardiology Conferences
16 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)

OBITUARIES

Dr. Samuel Breslow

Samuel Breslow, M.D. of Perth Amboy, who was instrumental in setting up the Abortion Law Study Commission and in the ultimate striking down of New Jersey abortion law, died on September 25 at New York University Hospital where he was undergoing treatment for a cardiac disorder. Born in 1906 and graduated from George Washington University School of Medicine, class of 1931, Dr. Breslow limited his practice to obstetrics and gynecology. He was affiliated in that department at Perth Amboy General Hospital and Memorial Hospital in South Amboy. In addition, he was director of the family planning clinic at the Perth Amboy Hospital. He was a Fellow of the American College of Obstetrics and Gynecology and of the International College of Surgeons, and was a member of the New Jersey Society of Obstetricians and Gynecologists and of the American Public Health Association.

Dr. Samuel B. Brown

One of Burlington County's senior practitioners, Samuel B. Brown, M.D., of Riverton, died on September 12, 1975, in Rancocas Valley Hospital. A native of Joplin, Missouri, Dr. Brown was graduated from Meharry Medical College in 1932 and until 1950 served as a member of the medical staff of the Tuskegee Veterans Administration Hospital in Alabama. At that time he came to Burlington County and practiced general medicine first in Burlington City, where he was school physician for 18 years, and more recently in Riverton. He was also medical director for the Head Start programs in Burlington City, Mount Holly, Moorestown, Palmyra, and Browns Mills. Dr. Brown was 71 years old at the time of his death.

Dr. Sydney Chayes

Word has been received of the sudden death on August 15, 1975, of Sydney Chayes, M.D., one of Bayonne's oldest practicing physicians. Born

in 1891 and a graduate of Bellevue Medical College in 1914, Dr. Chayes was for many years a member of the surgical staff at the Bayonne Hospital. He was a Fellow of the American College of Surgeons and of the International College of Surgeons and a diplomate of the American Board of Abdominal Surgery. He was actively interested in public health problems and served in Hudson County Tuberculosis clinics and as a member of the medical department of the Bayonne Board of Education. In 1964, he was a recipient of MSNJ's Golden Merit Award. Dr. Chayes served with the American Expeditionary Forces during World War I.

Dr. Charles T. Decker

At the grand age of 91, Charles T. Decker, M.D., formerly of Westfield, died on August 11, 1975, after a prolonged illness. Born in Brooklyn and reared in New Jersey, Dr. Decker was graduated from Columbia University's College of Physicians and Surgeons in 1906 and came to Westfield to practice general medicine; he continued to serve the people of that area until retirement in 1960. He had been associated with the Muhlenberg Hospital and was chief medical inspector for the Westfield Public Schools. Dr. Decker had been elected an emeritus member in 1962, through the Union County Medical Society.

Dr. Cedric E. Filkins

One of Camden County's senior physicians, Cedric E. Filkins, M.D., of Audubon, died on August 23, 1975, after a long illness. Born in 1888 in Rochester, New York, and graduated from Syracuse University Medical School in 1913, he pursued a residency at Pennsylvania Hospital in Philadelphia and then served six years with the medical department of the United States Army, during World War I and immediately thereafter. Upon release from the armed forces, Dr. Filkins came to Audubon and practiced general medicine there until retirement.

Dr. Joseph F. Gibney

At the untimely age of 50, Joseph F. Gibney, M.D., a member of our Morris County component, died on August 22, 1975. A native of Rye,

New York, Dr. Gibney was graduated from New York University Medical School in 1948 and served two years with the medical department of the United States Air Force before pursuing a residency in anesthesiology. Dr. Gibney was associated with the Dover General Hospital and was a diplomate of the American Board of Anesthesiology, a Fellow of the American College of Anesthesiology, and a member of the New Jersey and American Anesthetists' Associations.

Dr. William S. Goldfarb

William S. Goldfarb, M.D., a member of our Bergen County component, died suddenly at Hackensack Hospital on August 28, 1975. Born in 1914 and a graduate of New York University School of Medicine, class of 1941, Dr. Goldfarb took residencies in obstetrics, gynecology, and gynecological endocrinology at the Bronx and Bellevue Hospitals and at New York University Postgraduate Medical School. He practiced in New York City until 1961, when he came to Paramus to pursue further his medical career. He was on the active staff at the Holy Name Hospital in Teaneck and at Hackensack Hospital, and was clinical assistant professor in obstetrics and gynecology at New York Medical College. Dr. Goldfarb was certified by the American Board of Obstetrics and Gynecology and was a Fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecology.

Dr. Mary B. Hall-Shepp

Mary B. Hall, M.D., chief of the department of allergy at Helene Fuld Hospital in Trenton, died at her home on September 26, 1975, after a long illness. Born in New York City and educated at the Northfield Seminary, Smith College (where she earned her bachelor's degree), and the University of Pennsylvania College of Medicine, class of 1943, Dr. Hall did graduate work in allergy at Presbyterian Hospital in New York. She was a member of the American Academy of Allergists and American College of Allergy, and was a past-president of the New Jersey Allergy Society. She was the wife of Murray D. Shepp, M.D., a Trenton internist, and the eldest of their four children, a daughter, is a practicing physician in Brookline, Massachusetts. She was in-

terested in civic affairs and had been active with the Girl Scouts of America, the New Jersey Learning Disabilities Council and locally with the Parent-Teachers Association and the Zonta Club.

Dr. Harold J. Hoops

Word has been received of the sudden death on August 19, 1975, of Harold J. Hoops, M.D., formerly of Jersey City, in Palm Beach, Florida, where he had retired in 1968. Dr. Hoops practiced general medicine for some time and then pursued his interest in psychiatry, eventually limiting his practice to that specialty. He was associated with the Fairmont Hospital in Jersey City, and for a few years before retirement he located in Rumson and Asbury Park and was then associated with the State Hospital at Marlboro. Dr. Hoops was 78 years old at the time of his death.

Dr. Ralph G. Rohner

One of Essex County's well-known practitioners, Ralph G. Rohner, M.D., of East Orange, died on September 1, 1975. Born in 1907 and a graduate of the University of Virginia College of Medicine, class of 1936, Dr. Rohner pursued a career in orthopedic surgery and was board certified in his chosen field. He was a Fellow of the American Academy of Orthopedic Surgery and of the International College of Surgeons and was a member of the Academy of Medicine of New Jersey. He was affiliated with St. James, St. Michael's, and Presbyterian Hospitals in Newark, with St. Elizabeth's and Alexian Brothers' Hospitals in Elizabeth, and with the Hospital for Joint Diseases in New York. Dr. Rohner was associate clinical professor of orthopedic surgery at New Jersey Medical School.

Dr. Sidney Rosenblatt

Sidney Rosenblatt, M.D., an Atlantic City physician for 54 years, died on September 16, 1975, at Atlantic City Medical Center. A graduate of Jefferson Medical College in 1918, Dr. Rosenblatt was a general practitioner with special interest in rectal diseases. He had been on the staff at Atlantic City Medical Center and at the Clyde Fish Memorial Hospital. He was a

member of the American College of Physicians and of the American Protologic Society. He was a recipient of MSNJ's Golden Merit Award in 1968 and was elected to emeritus membership just this year. Dr. Rosenblatt was 82 years old at the time of his death.

Dr. Elmer W. Smalzried

At the grand age of 87, Elmer Smalzried, M.D., of Garden Grove, California, formerly of East Orange, died on September 18, 1975. A native of Indiana, Dr. Smalzried was graduated from Columbia University College of Physicians and Surgeons in 1918 and practiced general medicine in Essex County from the late 1920's to 1950 when he retired to California. His early years had been spent in medical work in China. Dr. Smalzried had been associated formerly with Orange Memorial, East Orange General, and St. Barnabas Hospitals.

Dr. Jacob Warren

One of Passaic County's senior members, Jacob Warren, M.D., of Paterson, died on September 27, 1975, at the age of 74. Dr. Warren received his doctorate of medicine from Jefferson Medical College in 1928 and following internship and graduate studies in surgery and gynecology, returned to his native city to establish a practice. He was a Fellow of the American College of Surgeons and a member of the New Jersey Obstetrical and Gynecological Society and of the Academy of Medicine of New Jersey. During his active practice he was associated with Barnert Memorial Hospital in Paterson.

Dr. Wilson D. Webb

One of Bergen County's Assistant Medical Examiners, Wilson D. Webb, M.D., of Hackensack, died in Hackensack Hospital on August 18, 1975, after a prolonged illness. Born in 1923 and graduated from New York Medical College in 1947, Dr. Webb pursued graduate studies in general and vascular surgery at the Mayo Clinic and at the University of Minnesota. He was board certified in his field and was a Fellow of the American College of Surgeons. He was a member of the active staff at the Hackensack Hospital and at the Pascack Valley Hospital in Westwood.

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BOOK REVIEWS

A Nice Neat Operation. Muriel Beadle. Garden City, New York, Doubleday, 1975 Pp 196 (\$7.95)

Why does it take so long for someone to answer the call bell in the hospital? The question has boggled the minds of many physicians and most patients for years.

A Nice, Neat Operation attempts to answer this question by describing the experiences of a fictional patient in a fictional hospital, contrasting the patient's experiences with that of the medical, nursing, and administrative staffs of the hospital. Along the way, the author presents some interesting historical data regarding the evolution of hospitals from places of refuge for the sick-poor to their contemporary positions as dispensers of cures for all the ills of all of mankind.

This format is a very difficult way to answer what seems to be a simple question. However, as most of us know, and the author points out repeatedly, the question is not simple. The answer, as provided in this book, is complex but very well presented.

The book is written for the layman rather than the health professional, necessitating some rather lengthy explanations for the professional segment of the population. Nevertheless, the writing has been done so well that the book continues to hold one's attention throughout.

The image created is of a suburban hospital trying vigorously to meet the challenges of patient care in today's environment. It does not deal with the infinitely more complex problems of large inner-city institutions. But the approach is interesting, the description of its solutions to various common hospital problems is thought-provoking, and the impact of the institution on the patient is important fodder for our collective think-tanks.

This book should be a Christmas gift to all hospital administrators, most physicians and nurses, and pre-hospital reading for anyone undergoing an operation. On second thought, maybe the last group should make this convalescent reading.

Mrs. Beadle rates three stars for an entertaining book.
William A Dwyer, Jr., M.D.

The Ocular Fundus, Third Edition. Arna Naver, M.D. Philadelphia, Lea and Febiger, 1974. Pp. 175. Illustrated. (\$19.50)

This is a well-conceived, interesting and well-illustrated little book that should be of value to the student, intern, and resident.

There is a brief, clear exposition of the principle of ophthalmoscopy followed by instruction on methods of ex-

amination. The anatomy of the retina and choroid is followed by lucid descriptions of the components of the normal fundus. Following this are brief descriptions, orderly and simply presented, of the changes that occur in congenital disorders, inflammation, vascular disorders, degenerative diseases, trauma, tumor and so on, all with excellent colored illustrations.

This is, then, a useful book for the tyro and a good quick review for the more experienced practitioner.

S. Jerome Greenfield, M.D.

Epilepsy. Alvin and Virginia Silverstein. Philadelphia, Lippincott, 1975. Pp. 64. (Paperback — \$1.95)

This brief paperback is designed primarily for young readers, but would be helpful to anyone who has epilepsy, or knows someone with it. It is written by two non-physicians, but their background in science and literature seems to have helped them in writing a very objective monograph. There is an introduction by J. Gordon Millichap, a well-known authority on epilepsy.

The book attempts to familiarize the reader with the many aspects of epilepsy, and in so doing dispel the myths and misconceptions that surround it. It talks about the history, treatment, and research of epilepsy and accurately describes the various types of epileptic seizures. Diagrams are clear and accurate. The book is up to date and includes some recent advances in the field such as cerebellar stimulation and biofeedback for control of seizures.

The book emphasizes the fact that epileptics can and should lead relatively normal lives, and lists many famous people such as Julius Caesar and Lord Byron, who were epileptics. There is a section on what to do if you observe someone in a seizure that presents good common sense advice.

This is a brief, but excellent, overview of epilepsy that should have wide appeal to the non-professional.

Lawrence D. Shor, M. D.

Inflammatory Bowel Disease. Joseph B. Kirsner, M.D. and Ray G. Sharter, M.D., Editors. Philadelphia, Lea and Febiger, 1975. Pp. 465. Illustrated (\$35)

This excellent book thoroughly reviews all the aspects of inflammatory bowel syndrome. Chapters divide the subject into epidemiology, etiology, immunology, microbiology, clinical features, local and systemic complications, IBD during pregnancy and childhood, pathology, diagnosis, differential diagnosis, radiology, and so on. The authors of the twenty-five chapters and the two editors are recognized experts and write well. Though thorough, the chapters are concise and can be completely read as a review or used for a quick glance after seeing a patient.

The book reviews the latest scientific literature and relates the well-digested material to clinical problems the practicing physician is likely to see. Trainees, academics, and consultants will find much of use here.

I strongly recommend this volume to interested readers. I consider it the best book on this subject and expect many subsequent editions in the future.

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December 1975

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Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it could depend on the medication in question. For example, in the case of an injectable long-acting progestrone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

ly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebotrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

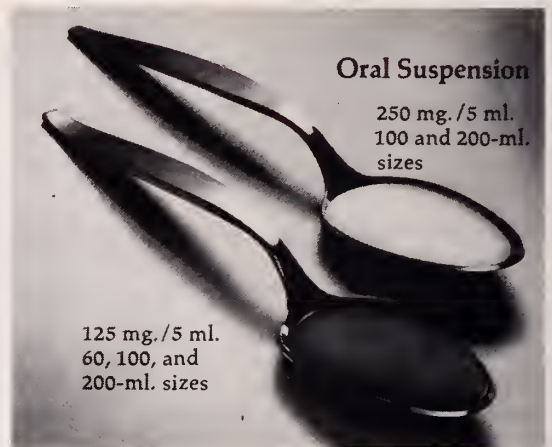
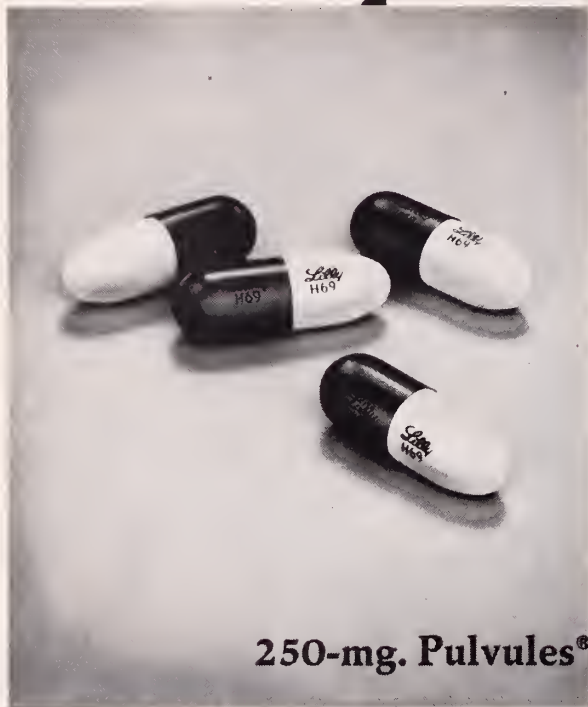
I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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EDITORIALS

Marcus H. Greifinger, M.D. 1900 — 1975

On October 21, after a long illness, Doctor Marcus Greifinger died. All who knew him will remember with grateful edification his life-long dedication to the best interest of his patients, his profession, and his peers — all of whom he consistently served with a kindly and quiet constancy.

The members of The Medical Society of New Jersey will especially recall his full score of years as Secretary of the Society. From 1949 to 1969, Doctor Greifinger efficiently and faithfully performed the duties of that office, ardently safeguarding member-interests in all things, but especially in working for a program of professional liability insurance that would be available and fair to all members in good standing. From 1961 through 1970, Doctor Greifinger was an elected representative of MSNJ in the House of Delegates of the American Medical Association.

He was a lifetime member of the Essex County Medical Society, whose Secretary he was from 1939 to 1955, and whose President he became in 1956-1957. He was a Past-President of the Physicians Club of Essex County and Police Surgeon for the City of Newark for about a quarter of a century.

A Fellow of the American College of Surgeons and a member of the New Jersey Society of Surgeons, Dr. Greifinger, before his retirement, served as an attending surgeon on the staffs of Clara Maass, St. James, and the City Hospital of Newark.

He is survived by his widow, Sylvia, and two daughters, Ruth Rothman, M.D., and Ilene. His brother, William, also a former President of the Essex County Medical Society, is currently a member of the Board of Trustees of The Medical Society of New Jersey. R.I.N.

Every Once in a While

With apologies to the reverent — a Pope died and went to Heaven, where he was warmly greeted by Saint Peter. After the completion of salutations, Saint Peter explained the rules and regulations to the Pope and underscored the fact that Heaven, unlike earth, was completely democratic. All residents were equal and none was shown special favors. The Pope acknowledged his acceptance of this concept, and said he preferred it that way.

When mealtime came, the Pope took a place in line at the heavenly cafeteria, but was a bit surprised when a distinguished figure, with a stethoscope around his neck, passed by everyone, went to the head of the line, took his food, and left. After lunch, the Pope sought out Saint Peter and, after describing the cafeteria incident, asked for an explanation. After reflecting a moment, Saint Peter said: "Oh, yes! That was God. Every once in a while he likes to play doctor."

As we approach the final quarter of the second century of our nation, it might be time for some people to consider the democratic way and see the other person's point of view. Perhaps it is time for Governor Brendan T. Byrne, Insurance Commissioner James J. Sheeran, and the members of the state legislature to stop "playing God" and just once try to see how it is "to play doctor" for a few minutes. These "all-knowing defenders of the public" might stay in an accident ward some Saturday night and observe, at first hand, the split-second decisions which must be made when the broken auto accident victims, the comatose diabetics, the cardiac-arrested heart patients, and the drug-abused teenagers are brought in for critical care. They might read an "informed consent form" to the shocky G.I. bleeder as his blood volume passes through his colon and the physician prepares to start a transfusion. They might explain to a distraught septuagenarian the dangers of emergency surgery on her near-dead spouse with a ruptured abdominal aortic aneurysm. They might share in the answer to the family of a decerebrate stroke victim, who is being maintained by electrical impulses, mechanical devices, and tubes in and out

of many orifices, when the question of "pulling the plug" is asked.

Perhaps the law-makers and the law practitioners should take their blinders off and look past that "contingency fee in the sky." They might see the utter destruction that they are causing to the most meaningful aspect of health care — the relationship between the patient and the doctor.

A.K.

The Medium Bars the Message

A recently-produced film purported to provide patients with some basic facts about diabetes and a glucose-oxidase technique for urine testing will probably "turn off" the majority of viewers in its first film minute. It shows a lady elegantly dressed and her fashion-plate child driving from a freeway in a large convertible car into a magnificent neighborhood of \$100,000 single homes. The pair then enter a *House Beautiful* kitchen with a bag of groceries while the off-stage announcer recites some truisms about diabetes.

This kind of "educational device" cannot teach the majority of clinic patients, the poor, the economically and educationally deprived, or even the majority of blue-collar workers' families. Such individuals cannot identify with scenes and people of this ilk, and thus the medium cuts off the audience from the message. Furthermore, the scenario contains the medical commentary and jargon which has been shown to interfere with doctor-patient communication.

The same problem exists in most of the health pamphlets which are written for an audience with intellectual levels and educational attainments far beyond the capacity of many of their readers.

Health educators are becoming increasingly aware of the need to prepare information and educational publications at two or three levels of formal education. Awareness of ethnic factors, language barriers, and the effects of aging must

also be considered or the educator is wasting his time, talent, and money. The purpose of education is to induce people to do things properly for the sake of their health or that of their family. They can't do any of that if they don't know what we are saying — in films, pamphlets, or conversation.

A.K.

AMA Membership

Recent reports from the American Medical Association suggest that there is a rekindling of interest and confidence in our national organization. The total dues-paying membership has reached an all-time high, after the third consecutive year in which a membership increase occurred.

In 1975, there are 173,221 paid physician members to date, which represents an increase of 6,100 over the same time a year ago. Surprisingly the most dramatic membership gains were among interns, residents, and medical students; there are 7,897 interns and residents in the AMA, a figure which represents an increase of 2,800 over the 1974 total. Medical student membership rose from 4,713 in 1974 to 7,467 in 1975.

Coupled with the 36,000 non-dues paying members* this gives a total membership in excess of 209,000 which suggests quite clearly that the events of recent years have enhanced the desire of many physicians to be associated with an organization which can lead with strength and maintain a leadership role in medical affairs.

There are still many non-members in the New Jersey medical community, especially among the faculty members of our medical schools. We hope our readers will urge all such physicians, medical students, house physicians, interns, residents, and faculty members to come into the one organization which is capable of representing our global interests in this time of crisis in medicine.

A.K.

*Dues-exempt members include physicians on military leave, in the U.S. Public Health Service, or on retirement status.

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Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension.* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has

been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and

BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Anti-hypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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ORIGINAL ARTICLES

In burn therapy today emphasis is on restoring the patient to physiological condition in the shortest possible time so that definitive debridement and burn wound coverage can proceed. Crystalloid replacement of initial fluid losses and hyperalimentation help to achieve this purpose. Silvadine and Sulfamylon* ointment, coupled with exposure therapy, daily tub bath and debridement, and repeated biopsy and bacterial count, help to keep down the infectious component of the burn problem. An additional assist is obtained by the judicious use of pigskin heterografts. The air-driven dermatone and the mesh graft technic provide a much more successful autograft than has been available previously. Finally, the air bed assists in patient comfort during therapy in a manner not previously possible.*

What's New in Burns?*

Curtis P. Artz, M.D.
Charleston, South Carolina

In the treatment of burns, the basic principles in surgical care must be kept in mind. A third degree burn always results in devitalized tissue which is incapable of resisting bacterial infection and, indeed, acts as a culture medium for bacterial growth. If an ordinary wound contained dead tissue, no surgeon would have the slightest hesitation in debriding it. A major burn wound, however, covers a large surface area and is associated with an initial profound derangement of the patient's total and circulating fluid volume which precludes initial surgical excision. It is against this background that all burn care has developed.

Fluid Balance

The first problem is the derangement of fluid balance. Looking back twenty-four years to the development of the old Brooke formula,[†] one can appreciate how far we've come. Those originally associated with its development never expected it to last more than a few years as a therapeutic guide. Therefore, the recent emphasis on crystalloid solutions and the realization that colloids are not usually required in the first 24 hours come as no surprise.

As you know, the Parkland Formula** states that the fluid requirements for the first 24 hours should be calculated on the basis of four ml. of crystalloid solution (preferably Ringer's lactate) per percent burn per kg of body weight. This is probably excessive. About three ml. of lactated Ringer's solution per kg per percent of burn is

about right as an estimate for the first 24 hours. The rate of flow of the solution is determined by the urinary output which should be maintained at about 50 ml/hr. Colloid solutions and five percent glucose in water are used, as indicated by progressing hemoconcentration, in the second 24 hour period.

Respiratory Injury

The treatment of respiratory injury has also made significant progress with the use of corticosteroids and blood gas analysis among our diagnostic blood chemical determinations. The diagnosis of such an injury is dependent first upon the suspicion of its existence, and then the development of hoarseness and cough and the auscultatory finding of rales. It is always a difficult diagnosis.

Treatment consists of immediate administration of corticoids (Solumedrol[®]) at a dosage of 20 mg/kilo of body weight, as an immediate dose, followed by the same amount divided into four doses administered at six hour intervals. The steroids can be given without fear of an influence on the immune response during the first 48 hours post-burn. Additionally, treatment is started with wide-spectrum antibiotics and inhalation

*The Spencer T. Snedecor Trauma Oration delivered on May 31, 1975, 209th Annual Meeting of The Medical Society of New Jersey, Cherry Hill, New Jersey. Dr. Artz is Professor of Surgery and Chairman of that Department, Medical College of South Carolina.

†Artz, C P: The Brooke formula. In: *Contemporary Burn Management*. Polk H C Jr and Stone H H (editors). Boston, Little, Brown, 1971. Pp 43-51.

**Baxter, C R: Crystalloid resuscitation of burn shock. In: *Contemporary Burn Management*. Polk H C Jr and Stone H H (editors). Boston, Little, Brown, 1971. Pp 7-32.

therapy of moistened oxygen. Blood gases are monitored and should the PO_2 reach 60 or below, naso-tracheal intubation and/or tracheotomy is carried out. In all instances, naso-tracheal intubation is done first; if the PO_2 falls to 50 or below a tracheotomy is performed.

Local Treatment

With these advances in systemic care have also come significant advances in the local care of the burn wound.

The ideal, in terms of basic surgical principles, is complete excision of devitalized tissue with as rapid a restoration of skin cover as possible. Indeed, in many third degree burns involving less than 15 percent of the body surface, this should be the preferred approach. Some highly specialized centers are primarily excising burns of 40 percent or more, but it should be emphasized that for the average hospital primary total excision is impractical above 15 percent of the body surface. Outpatients with minor burns are probably best treated by covering the burns with dressings. The most suitable local antibacterial agent is currently the subject of considerable debate. The use of silver nitrate wet dressings has largely been abandoned because of its messiness, difficulty in implementation, and its effects on the patient's electrolytes. In its place has come Silvadine® (a combination of silver and sulfadiazine in ointment form). This is painless, produces a soft eschar which is easy to debride, and is effective in controlling local bacterial growth. Sulfamylon®, despite the pain associated with its use and its effect on the carbonic anhydrase system, appears to be somewhat more effective in controlling local bacterial growth.

In extensive burns, the relative effectiveness of the agent being employed should be judged by bacterial count carried out on a full thickness wound biopsy which is submitted to the pathology department every two or three days.

Since gentamycin is specific for pseudomonas, it is used only on demonstration of invasion by this organism, but it is not used as an ointment. A normal daily dose for the patient under treatment is dissolved in a 500 cc solution and then injected into the burn area beneath the eschar.

Wound Coverage

All patients with major burns are cleansed daily in a tub (this is especially important where Sulfamylon® is used) and local debridement is carried out at this time. Debridement and wound coverage are instituted as soon as the patient's condition permits. For this purpose homografts are useful as a biological dressing. While they are short-lived, they do provide interval coverage, allowing the patient to grow more of his own skin and to gain ground nutritionally.

Heterografts also are useful as biological dressings. While requiring replacement at much more frequent intervals, they are useful in preventing fluid loss, minimizing infection, and providing additional surface coverage in larger burns where autografts are not available. Furthermore, in infected areas where an autograft is not likely to take, they can be used initially to provide cover while awaiting the elimination of the infection.

Autografts are, of course, the definite answer to coverage. The air-driven dermatone available today allows for simplicity of operation and provides a superior piece of split-thickness skin. In addition, the ability to prepare the originally obtained skin in mesh graft fashion (increasing its square area coverage by a ratio of 1.5:1) has made possible much greater strides in initial autograft coverage. The mesh grafting technic also aids in preventing autograft loss by conforming better to body contour and allowing drainage of fluid.

Other Developments

In burn cases everyone is aware of the loss of protein both in the exudate and through the urine. The development of hyperalimentation therapy has been a major advance in overcoming the problem of replacing these losses. There is an obvious need for meticulous care of the intravenous catheter when this approach is used as these solutions are ideal culture media. They must be changed every five to seven days.

The latest development in the burn field is the air bed which floats the patient. This eliminates pain, provides a dry surface on the back and makes the patient rest better.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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orders, possibility of increase in frequency and/or severity of grand mal seizures require increased dosage of standard convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar those with barbiturates and alcohol) have occurred following abrupt discontinuation (convulsions, tremor, abdominal and leg cramps, vomiting and sweating). Use with caution in alcohol- and drug-addiction-prone individuals under car-

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, though primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent

in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

veillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider fully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors or other antidepressants may potentiate sedation. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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The etiology of coronary heart disease remains as controversial today as two decades ago, despite the tremendous accumulation of epidemiological data in the interim. Factors of major importance appear to be diet, hypertension, and smoking. Water supply and trace metals, drugs, and exercise are apparently of some importance, but the mechanism is less clear.

A Review of Some Epidemiological Factors in Coronary Heart Disease

**Marvin L. Bierenbaum M.D.
Montclair***

No area of research in the past ten years has yielded a greater accumulation of data than the epidemiology of coronary heart disease. Particular attention has been paid to the role of blood lipids in this problem since these parameters lend themselves to correction by both drug and dietary measures and since numerous studies strongly suggest that persons with lower levels have less coronary heart disease than those with higher levels. One can quite properly argue that the benefit to be derived from lowering lipids by drug therapy is still unsettled. This is particularly true, since a very recent report of a cooperative postcoronary drug study¹ here in the United States utilizing estrogens, clofibrate, and nicotinic acid showed only borderline improvement in recurrence rates for the last drug with no improvement in recurrence or mortality rates for the first two. Within the next few years, however, the results of a primary study with clofibrate in Europe should help to further clarify this issue.

Diet

The matter of dietary management of blood lipids is somewhat different however. There has been a greater and longer period of data collection of lipid changes, associated morbidity and mortality rates, and toxic side effects of special diets. Our ten-year study of younger men with proved coronary heart disease² showed, after weight reduction, that a 28 percent fat diet, containing less than 9 percent of calories as saturated fat and less than 400 mg. of exogenous cholesterol daily, was one method of lowering blood lipids and significantly improving mor-

bidity and mortality rates from subsequent coronary episodes. In this study, because of the restricted fat and exogenous cholesterol, the degree of unsaturation of the diet did not appear to influence either serum lipid values or mortality rates. The greatest benefit was derived by the younger age group, under 45, which suggested that necessary dietary change should be made early in life. Because of the considerable fat restriction, dietary adherence was always difficult and required constant urging and support to achieve success throughout the entire period of study.

On the other hand, studies by Miettinen and associates,³ Leren,⁴ and Dayton and associates⁵ revealed beneficial cardiovascular effects by improving blood lipids through the addition of considerable amounts of polyunsaturated fat to the usual diet; this was both palatable and readily acceptable to the volunteers. One fact emerged from the Pearce and Dayton study⁶ which was somewhat alarming and required careful evaluation. Despite improvement in cardiovascular death rates, the total mortality rate in the older cohorts was similar, but the noncardiovascular deaths in the patients on polyunsaturated fat showed an excess mortality from carcinoma. To add to the anxiety, Pinckney⁷ associated increased cancer incidence with increased dietary polyunsaturates as well as premature aging of the skin. A careful review of the cancer incidence of a number of other field trials using highly unsaturated diets, done by Ederer and associates,¹⁸ did not show an increase in the incidence of carcinoma. Hopefully, this issue will now be laid to rest.

*Dr. Bierenbaum is Director, Atherosclerosis Research Group, St. Vincent's Hospital, Montclair.

Additionally, evidence has emerged which showed that polyunsaturated linoleic acid has a pronounced and significant effect on reducing platelet aggregation in man.⁹ This effect may aid the reduction of the incidence of ischemic heart disease as reported in these studies, through a beneficial alteration of the clotting process. The coagulation mechanism has virtually been overlooked to date because of the marked difficulty in reproducing platelet findings. However, an in-vivo technique of platelet function^{9, 10} in various disease states may help to clarify the important role of thrombosis in the atherosclerotic process.

Water Supply

The relationship between cardiovascular disease and the mineral content of drinking water has also received increased attention from investigators throughout the world. Following the stimulating monograph by Kobayashi,¹¹ Schroeder¹² reported a negative correlation between cardiovascular disease mortality rates in the United States and the level of hardness of water. This negative correlation — the harder the water the lower the mortality rate from cardiovascular disease — was confirmed by Morris, *et al.*¹³ in England and Biorck, *et al.*¹⁴ in Sweden. An analysis of autopsy data in London and Glasgow by Crawford and Crawford¹⁵ suggested that there was an increased susceptibility of the myocardium to arteriosclerosis among men living in Glasgow, a soft water area. Robertson¹⁶ subsequently found that softening a water supply by replacing calcium ions with sodium ions, was associated with a higher cardiovascular mortality rate in the community seven years after receiving the softened water. He suggested that this might be related to the lower calcium content. Earlier, Morris¹³ had found a greater association with calcium than with hardness. In addition, Fleischman, *et al.*¹⁷ showed that calcium, in a poorly absorbable form, has a significant hypolipemic effect, possibly the result of interference with absorption of fat and cholesterol and the fecal excretion of bile acids. Anderson¹⁸ suggested that the higher cardiovascular mortality in soft water areas was primarily related to sudden death and might have resulted from lower serum calcium levels leading to increased myocardial irritability, arrhythmia, and death. This intriguing possi-

bility received considerable support from the report of Rodstein, *et al.*¹⁹ which showed a higher sudden death rate of members of an insured population previously demonstrating premature ventricular contractions on the electrocardiogram at the time of initial examination.

In an extensive review, Masironi²⁰ mentioned several additional mechanisms including the possibility of "some toxic factors" in the soft water supply which might be responsible for the increase of cardiovascular mortality. In a further review of the problem, Schroeder²¹ proposed that the only state that could unfavorably affect all of the various conditions set forth was arterial hypertension. In addition, cadmium, which is found above safe limits in tap water from soft water areas, can reproduce the clinical and pathological picture of hypertensive disease in rats. This required careful consideration in attempting to resolve the water factor.

With all of the epidemiological data relating lipids to coronary heart disease, a logical question was whether or not men living in a hard water area have lower levels of serum lipids than their counterparts in a soft water area. This is of special interest because the calcium content of the hard water consumed might make an important contribution to the overall calcium intake. With this in mind, a sampling study was done, choosing two hard water areas in different settings with varied social factors (Omaha, Nebraska, USA, and London, UK), and two soft water areas (Winston-Salem, North Carolina, USA, and Glasgow, UK). In both Omaha, Nebraska, and London, England^{22, 23} serum lipids were either higher than or similar to those found in the soft water areas of Winston-Salem, North Carolina, and Glasgow, Scotland. The serum lipids appeared to mirror the diet of the area rather than the water composition. The water composition appeared to be more closely related to various serum ions such as magnesium, copper, chromium and cobalt.

Trace Metals

It is possible that trace metals may act through a mechanism other than controlling lipids. The action of cadmium as a hypertensive agent in animals has been well documented²⁴⁻²⁸ as has the effect of zinc on counteracting the cadmium

effect.²⁹ In a recent review, Perry correlates much of this data on hypertension.³⁰ Two additional elements which have been studied in our laboratory are fluoride³¹ and lithium.³² Fleischman, *et al.*³¹ studied two communities using the same water supply; one fluoridates the water but the other does not. The study showed that fluoride had no direct effect on the lipids and did not directly affect age in specific heart disease mortality rates of the areas. In the fluoride-treated community, elevations were noted at the 99 percent confidence level in serum calcium, magnesium and inorganic phosphorus concentrations.

Lithium,³² on the other hand, appeared to have blood glucose lowering effect in rats with hyperglycemia. This offers a possible mechanism for suggested lower rates of coronary heart disease in water regions with higher lithium content. In a clinical study, Bierenbaum, *et al.*³³ noted a strongly significant relationship of water cadmium to serum cadmium, elevated blood pressure and increased coronary rates. This again suggests a toxicity factor. While much has been done, the relationship of trace metals to cardiovascular disease and its complications still requires clarification.

Smoking

The role of smoking and its noxious effects on coronary disease, which has been known for a considerable period of time, was recently reported in a long term study evaluating this factor.³⁴ The Framingham study followed a cohort of men and women, aged 29-62 when first seen, for 18 years.³⁶ Among 2,336 men who were characterized by smoking status at entry, death-rates and coronary heart-disease attack-rates were found to be low for non-smokers, men smoking only cigars or pipes, and men smoking 10 cigarettes or less a day. Death and coronary heart disease rates among men smoking more than 10 cigarettes a day at entry were distinctly higher. Furthermore, men who were cigarette smokers at entry and subsequently stopped smoking had coronary heart disease attack-rates which were half that experienced by those who continued to smoke. This difference was not explained by changes in coronary risk factors. Overall mortality was lower in men who had

given up smoking than in men who continued to smoke. The mechanism for these changes is still not clear. One cause may be nicotine-induced release of catecholamines and subsequent increase in platelet stickiness and aggregation.³⁵

Hypertension

Insufficient attention has been paid to the role of hypertension, to this point, despite the tremendous accumulation of information on this subject and its widespread dissemination. Hypertension is still the most significant risk factor in coronary heart disease³⁶ and its control in this disease, and in cerebrovascular disease, is of utmost importance.

Exercise

Despite many papers^{37, 38} about exercise in recent years, little definitive data have accumulated. The mechanism or reputed benefits of exercise in coronary heart disease are uncertain but the subject deserves careful evaluation.

Summary

It should be evident, from this brief review of epidemiological factors in coronary heart disease, that much has been done in the past 15 to 20 years to bring some order to the very large list of potentially important factors. It should also be equally evident that much more work will be needed before the final answers are at hand.

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Combined Early Approach to Closure of Large Meningomyelocele*

**Richard B. Bloomenstein, M.D. and
M. Bernard Winkler, M.D./Fair Lawn**

The birth of an infant with spina bifida and myelomeningocele poses difficult problems in medical management. Not the least of the problems is the operative closure of the defect. The weight of accumulated evidence, to which many neurosurgeons now subscribe, clearly indicates that closure of the defect within the first day of birth increases the child's chances for survival.^{1, 2, 3, 4} Improvement of the motor defects¹ or at least, preservation of the motor power present at birth² are other advantages of early closure. Although the degree of physical handicap and dependency may vary greatly in surviving infants, even custodial care of the child in the "vegetative" category will certainly be much simplified after successful closure of the defect.

The role of the neurosurgeon is paramount in overall management. He must make early assessment of the degree and severity of neurological impairment and the concomitant occurrence or development of hydrocephalus. The role of the plastic surgeon is to close the larger myelomeningocele defects.

In many cases, the closure of the myelomeningocele should present no special problem to the neurosurgeon because it is small. The bony defect is always smaller than the overlying sac. Closure begins with dissection and return of the neural fibers and reconstruction of the spinal cord by dural suture. The dural closure is reinforced with adjacent fascial flaps and the skin is then closed by undermining and approximation.⁴

Closure of Large Meningocele Defects

When the meningocele defect is so large that

closure by simple approximation of adjacent tissue layers is impossible or too precarious, the surgeon must have familiarity and experience with a variety of means to repair large soft tissue defects.

Relaxing incisions forming bipedicle skin flaps might be used to avoid tension on the skin closure. The secondary defects on each side of the original skin defect are then permitted to heal by cicatrization, or are skin grafted. Some surgeons⁴ still advocate the closure of large myelomeningoceles by extensive undermining and advancement or rotation of large skin flaps from the surrounding area, either as one step or in two stages (the first being a preliminary "delay"). A split thickness skin graft or skin advancement may then be required to cover the secondary defects, i.e., the bed of the rotated flap. These maneuvers add considerably to the extent and formidable nature of operations performed on a newborn. Blood loss of 250 cc. to 800 cc. has been reported with such procedures.⁶ If the repair of the meningocele is to be done as an emergency in the first day or two of the infant's life, it should be performed in a manner that is expeditious, comparatively simple, and associated with low morbidity and mortality. The integrity of the deep closure should not have to depend on the rather precarious blood supply of widely-undermined skin flaps, although the viability of such flaps might be estimated by infra-red thermometry⁵ or other means at time of surgery. It is no longer necessary to accept as

*Read before the Sections on Neurosurgery and Neurology, Plastic and Reconstructive Surgery, 209th Annual Meeting, The Medical Society of New Jersey, Cherry Hill, June 1, 1975. Dr. Bloomenstein is Senior Attending Plastic Surgeon, and Dr. Winkler is Director, Department of Neurosurgery at St. Joseph's Hospital, Paterson. Address requests for reprints to 25-15 Fair Lawn Avenue, Fair Lawn 07410.

inevitable the development of infection and slough in the closure.

Modified Mustarde Procedure: Results

We now use a modification of the type of wound closure proposed by Mustarde^{7, 8} for the closure of large meningoceles. We have treated seven such infants with defects (after removal of sac) ranging in size from 4 to 8 cm (Figures 1 and 2). Results are summarized on the accompanying table. All were operated upon during the first day of life. Each child was closely followed by a neurosurgeon and required a cerebrospinal fluid shunting procedure at a later date because of



Figure 1 — Typical myelomeningocele — preoperative



Figure 2 — Same patient after closure with muscle-bone flaps and skin graft

hydrocephalus. Subsequent urologic and orthopedic procedures were needed in six children as they grew. There were no operative mortalities. One child died of pneumonia two months after repair. All myelomeningocele closures were performed under local anesthesia. The maximum blood transfusion was 50 cc. during surgery.

Surgical Technique

Our surgical procedure employed for closure of the large spinal myelomeningocele defect is based on Mustarde's technique and proceeds as follows:

Table

Summary of Cases

Patient	Age (Hrs.)	Location	Defect (CM.)	Blood Loss (cc)	Followup
1	20	L3-S1	5	40	L & W*
2	12	L1-L4	6	20	L & W
3	15	T12-L4	8	25	Pneumonia
4	10	L1-L4	6	50	L & W
5	8	L2-L4	5	35	L & W
6	10	T12-L3	8	20	L & W
7	16	L1-L3	4	0	L & W

*Living and well

The first phase of the operation is a dye outline of the surrounding normal (although often red-pigmented) skin to separate it from the atrophic scar-like covering of the meningocele sac tissues. An elliptical incision is made at this line, and followed by a meticulous debridement to discard the atrophic skin and dissect the meningocele sac with identification and preservation of all possible nerve elements. This is followed by mobilization of the dura and closure with interrupted sutures of fine silk to form a tube around the neural elements. In most cases, there is fusion of all ectodermal elements in the center of the meningocele, therefore, it is necessary to sacrifice some nerve elements or to bury them, including the exposed surface. We bury this plaque in babies whose surgery is performed within six to 24 hours of birth, but we feel that the risks of contamination are too great after this time and so excise and sacrifice the plaque and its attached nerve elements in delayed cases.

If the defect is in the lumbar or lower thoracic region, the next step consists of a longitudinal incision into the right and left sacrospinalis muscle masses and infractioning of the splayed-out, unfused spinal processes which lie almost horizontally. The spinous processes, with the adjacent paraspinal muscles are rotated up and over the dural closure to reform partially the dorsal osseous wall of the spinal canal. In the lower lumbar region and below the level of the iliac crest, movement of bone will not be possible (although Mustarde recommends mobilizing the muscle masses with a slice of cartilage from the iliac crests.)

In our adaptation of the Mustarde operation, we have not hesitated to mobilize the muscle-fascia mass without bone and have done so in four cases. In two patients, the defect was in the lumbar area and the splayed-out spinous processes could not be easily infractioned. We turned over the muscle mass without them, rather than add operative time and potential morbidity.

In the other two cases, the defect was low lumbosacral or sacral in location and the muscle mass was again mobilized without bone. These wounds healed well. When the muscle-fascia mass is mobilized, the fascial layer comes to lie next to the repaired cord and forms a firm and

resilient reinforcement. The muscle-fascia mass is closed as one or two layers, using buried chromic catgut sutures or a pull-out steel wire suture. The muscular mass is a well-vascularized bed which readily accepts a split-thickness skin graft. The excellent blood supply in the muscle mass assures protection of the meninges. The vascular supply to the skin covering, supported by the muscle mass, is far superior to that of a widely undermined skin flap devoid of an intact subcutaneous circulation (as in older methods). The skin-grafted muscle closure in our patients has held up well and has shown as great a resistance to pressure and subsequent breakdown as have the closures by skin flap over the muscle closure. Such skin-grafted muscle flaps are common and have been used in other body areas for decubitus ulcer repairs, with good subsequent protection. Our technique departs from that of Mustarde in our willingness to close some skin wounds without a skin graft. We triangulate and advance the skin margins, when possible (Figure 3).

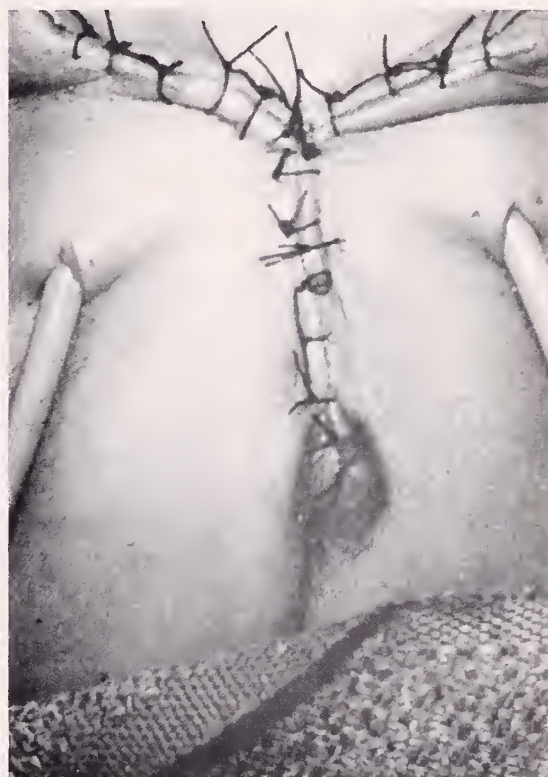


Figure 3 — Another patient with postoperative closure by triangulation without skin graft. Note lateral drain catheters.

Summary

The purpose of this paper is to emphasize the fact that recent advances have greatly improved the chances for successful, complete closure of the meningomyelocele defect in one stage in newborns. With the growing belief that afflicted children should be operated upon, and with an increased surgical armamentum available, we believe more infants will come to surgery.

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Rheumatology — Sheldon D. Solomon, M.D.*

1. The rheumatoid variants include: ankylosing spondylitis, inflammatory bowel disease, Reiter's syndrome, and psoriatic arthritis. TRUE or FALSE
2. One of the distinguishing features of the rheumatoid variants is the fact that all of them have a high incidence of axial involvement. TRUE or FALSE
3. Rheumatoid factor tests are strongly positive in these conditions. TRUE or FALSE
4. Recently the HL-A27 antigen has been found in high association with these diseases. TRUE or FALSE
2. TRUE. Usually the spondylitis clinically is more significant than peripheral joint involvement.
3. FALSE. Rheumatoid factor is only positive in these conditions usually in about 10 percent or slightly greater than the normal population.
4. TRUE. This transplantation antigen has been found to be positive in 90 percent of patients with ankylosing spondylitis, 85 percent of patients with Reiter's disease, and a high percentage of patients with inflammatory bowel disease.

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*From "The Cooper Review" (August 1975) published by the Department of Medical Education, Cooper Medical Center, Camden, New Jersey, where Dr. Solomon is Chief Attending Rheumatologist.

Answers:

1. TRUE. For a long period of time now these diseases have had certain common features which are unique to them and separate them from rheumatoid arthritis and for this reason have been called rheumatoid variants.

Cryosurgery for internal and external hemorrhoids is an effective method of treatment. There is amazingly little discomfort during and after surgery. The complications encountered are minor. A great advantage is the avoidance of hospitalization and anesthesia.

Cryosurgery for Hemorrhoids

Stanley P. Wegryn, M.D.
Sanibel Island, Florida*

While the use of cryosurgery in the treatment of hemorrhoids is relatively new, a firm footing for its use has been established by Lewis^{1,3,4} and Williams.² A detailed discussion of the pathophysiologic aspects of cryosurgery has been presented by Von Leden.⁵

This article will review my experiences with 100 consecutive cases, and will describe the preoperative approach to the patient, the operative technique, and the postoperative results over a thirty-month period.

Basic Principles

When frozen, small vessels are destroyed faster than large ones due to intimal swelling,⁵ which quickly occludes the former. Collagen-rich tissues are more resistant than other tissues to freezing, while large vessels, with greater warm blood flow, resist freezing.¹

Preoperative Care

All patients undergo a thorough proctologic evaluation which includes a history and physical examination as well as a barium enema study of the colon and sigmoidoscopy. Where indicated, laboratory evaluation, electrocardiogram and medical consultation evaluation are also obtained.

Some time is taken to explain the procedure in detail to the patient. Tissue cells are analogized to little water-containing containers which can be cracked open by freezing the contents. This is attributed to the expansion in size of the contents beyond the volume capacity of the cell which ruptures (dehydration)¹ as a consequence. The patient is told that the hemorrhoids are likely to almost double in size in the immediate

postoperative period because of this expansion. The pre-operative complaints of our patients are summarized in Table I.

Table I
Pre-operative Complaints

Complaint	Percentage of Patients
Protrusion	100
History of bleeding	97
Pain	41
Itching	38
Discharge	6
Marked irritation	5
Previous surgery	3

The only preoperative preparation is a Fleets Enema[®] given to the patient shortly before the cryosurgery. The patient is warned that he will have a watery discharge (composed of potassium, protein, and water)³ for approximately two to three weeks,¹ and that it may have some blood mixed with it.

Postoperative pain is likened to that burning cold sensation produced by a minimal exposure of bare skin to intense cold.

For pain relief, one gram of aspirin is prescribed every four hours as needed; additionally an anesthetic ointment and three or four tub baths daily may be ordered. For relief if constipation should develop, the patient is advised to take milk of magnesia, but if diarrhea occurs, he is instructed to call the surgeon for advice.

Operative Technique

The patient is placed in the lithotomy position,

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which permits him to reach down and help in gluteal retraction. He may also aid in the identification of the hemorrhoids by voluntary pressure. An anoscope or small vaginal speculum may be needed in the procedure, during which special note of any bleeding points is made.

The Syntex® CO₂ unit, with a pencil-thin probe and a conical probe is employed in all cases. When an external hemorrhoid is adjacent to an internal hemorrhoid, the conical probe is used. First, the distal edge of the external hemorrhoid is frozen to the edge of the conical probe. The probe is then arched to endeavor to attach the remainder of the conical probe to the internal hemorrhoid. If the internal hemorrhoid is a discrete entity, the pencil probe is placed over it. The excess tissue encircles the probe. This maneuver obviates the need of proctoscopic visualization throughout the entire process.

The average time of freezing is four minutes,² however, internal hemorrhoids tend to need less time, while hyperkeratotic external hemorrhoids take longer. In any case, the time is not the criterion of completion. When there is a two to three millimeter area of white tissue around the frozen hemorrhoid, the procedure is complete. Often hyperkeratotic external hemorrhoids need refreezing for approximately one minute.

Post-Operative Results

Patients respond well to the procedure, although some complained of pain. The majority described the discomfort as a "cold burning feeling." The best responses were from patients who had had previous surgery for hemorrhoids.

The patients were routinely seen three and six weeks after surgery. After three weeks, the area of cryosurgery was 90 percent healed and at six weeks it was completely healed. Those patients who were less well healed at three weeks had had diarrhea or constipation, or had not followed the

post-operative instructions. It is far too soon to evaluate recurrence rates, although in this series there were no recurrences. The post-operative complications are summarized in Table II. It was almost impossible to determine exactly how soon most patients would be able to return to work. Lewis⁴ stated that 98 percent of his cases were able to return to work the following day, but we found this statistic difficult to validate. Both employers and patients are aware of the usual convalescent time for hemorrhoidectomy. Thresholds of pain, the need for attention, and other subjective factors are involved in the "back-to-work" determination, but many patients want maximum time off for convalescence. Two executives, who could not afford to miss work, were working the day after cryosurgery.

Table II
Post-Operative Complications

Complication	Percentage of Patients
Discharge	100
*Bleeding	12
**Repeat Procedure	2
***Fissure	1
Painful first bowel movement	1
*None worse than that prior to cryosurgery	
**To freeze an area inadequately frozen on the first procedure	
***Healed in three weeks	

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Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

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Croup and epiglottitis are distinct diseases that produce upper airway obstruction. The former is often mild, can be treated symptomatically, and only occasionally requires surgical intervention. Epiglottitis, however, is unpredictable and necessitates early relief of obstruction. Diagnostic aids and treatment for each disease are discussed.

Croup and Epiglottitis

Current Diagnosis and Therapy

Richard H. Rapkin, M.D.
Green Brook

In 1948, Rabe¹ described the croup syndrome in three classic papers. He studied more than 300 patients with an infectious form of croup admitted to New Haven Hospital over a ten-year period. Rabe separated croup into three major categories: diphtheritic, hemophilus influenzae type b, and viral, and found that there were 22 cases caused by *C. diphtheriae*, 28 caused by *H. influenzae*, and in 297 cases there was no etiology determined.

Viral Croup

Rabe indicated that viral croup could be defined as such by the absence of a consistent bacterial pathogen, and by a typical clinical syndrome in which there was an antecedent upper-respiratory infection with rapid or sudden development of respiratory stridor and hoarseness, usually occurring first at night. By the time of hospitalization, most children were in respiratory distress but not toxic. Some were severely distressed. Physical findings in these patients included redness and edema of the mucosa of the pharynx, larynx, and trachea associated with much secretion. Supraglottic edema was never noted by Rabe in his series of viral croup, although the area was frequently injected.

Eighty percent of the viral croup patients presented between October and April, and the child's age was less than three years more than sixty percent of the time. Twelve percent of these patients needed tracheostomy, and two percent died.

Studies subsequent to Rabe have defined the viral etiology of non-bacterial croup. Chanock²

and co-workers demonstrated the role of the Parainfluenzae myxoviruses (previously called "Croup Associated Viruses") as the most frequent cause of viral croup. Other frequent viral associations have been influenza A and B, Adenovirus type 5, ECHO type 13, and the Respiratory Syncytial Virus. Chanock studied more than 8000 patients with respiratory infection, and out of 340 cases with laryngitis, 53.5 percent were defined as to etiology. Parainfluenza Virus was found in 30%, Respiratory Syncytial Virus in 6 percent, and Adenovirus in 4 percent.

Epiglottitis

Rabe's¹ description of Hemophilus influenzae type b croup from the 28 cases he had seen was excellent. Bacteriologically, Hemophilus influenzae type b was isolated in 82 percent of the patients in the nasopharynx, and in 89 percent of patients in the blood. The age incidence was different than viral croup: only 20 percent occurred under age 3 and 65 percent occurred from age 3 to age 7. The seasonal incidence was similar to viral croup. The history was brief. Only 25 percent had a preceding upper respiratory infection. More than one-half of the patients had the sudden onset of sore throat and rapidly developed progressive symptoms of respiratory obstruction. All of these children presented with severe prostration out of all proportion to the short duration of the illness, which averaged only 8 hours.

On physical examination, all of the children had marked pharyngitis, and in the 80% of patients whose epiglottis was seen, it was brilliant red and markedly swollen. Many of the patients had tender cervical adenitis. The average white blood count was 23,000 and the differential count in-

cluded usually 85 percent polymorphonuclear leukocytes. Thirteen of the 28 patients had tracheostomy and there were five deaths.

In 1958, the second landmark study of *Hemophilus influenzae* type b croup (now called epiglottitis) was made by Berenberg and Kevy³ at Boston Children's Hospital. Forty-six children seen in 8 years were analyzed. Thirty-one patients were over 2 years of age. All patients had been ill less than 24 hours at the time of admission. Berenberg and Kevy called attention to symptoms in which great throat pain, dysphagia, excessive drooling, and copious puddling of secretions, were frequent. Hoarseness and "croupy crow" were found in less than one-third of the patients. Fifty percent of the patients did not have bacteriologic confirmation of *Hemophilus influenzae* type b, but had the syndrome nevertheless. No other bacteria of significance were found. Eighteen of the patients were tracheostomized and five died (none of those who were tracheostomized died).

Berenberg and Kevy³ pointed out that only one of 42 children was diagnosed prior to admission despite the "classical" presentation. They felt that adequate examination of the pharynx would have made the diagnosis in most, and urged that this be mandatory.

Unfortunately, difficulties in envisioning the epiglottis have been noted by many observers. In 1963, Poole and Altman⁴ had 2 of 6 patients whose epiglottis could not be seen. In Rabe's series,¹ there were 6 of 28 patients whose epiglottis was not seen. Raj⁵ and co-workers stated that direct laryngoscopy was frequently necessary to observe the epiglottis.

Diagnosis

There is also difference of opinion regarding the safety of attempts to visualize the epiglottis. Many pediatricians know of a patient who suddenly stopped breathing when examined, and there has been much documentation in the literature of this phenomenon. Those who have seen it have advocated alternative means of diagnosis. Although there have been no controlled studies to resolve this, most responsible physicians would agree that a simple, reliable,

non-dangerous test to diagnose epiglottitis rapidly would be welcomed. In recent years, lateral neck films have been suggested as a rapid and accurate method.⁶ With current radiologic developing procedures, this can take less than five minutes. In a study done in 1971,⁶ lateral neck radiographs were found to be an efficient, safe, and reliable technique for assessing the presence of epiglottic swelling, and, therefore, the diagnosis of epiglottitis. The technique involved the patient's physician accompanying him to the x-ray department where, while the patient was sitting upright, a film of the lateral neck was obtained, promptly developed, and read by the child's physician. A diagnosis of epiglottitis could be made on the spot. Only minimal training was necessary to be able to read these films. Appropriate therapy could then be instituted.

Treatment

What is appropriate therapy for patients with croup or epiglottitis? Most data on the treatment of viral croup indicate that hydration, mist, and other non-specific supportive measures are appropriate in this disease. Although nebulized epinephrine has its advocates, controlled studies do not indicate its unquestioned value.⁷ Corticosteroids have also been suggested by some, but, again, controlled studies have failed to support their use.⁸ Careful monitoring of the child is essential in order effectively to decide when intervention (tracheostomy) is necessary. Following of blood gases, especially pCO_2 , is a very valuable means of determining the need for surgical intervention. The average patient with viral croup presents with a low pCO_2 ; despite his distress, the pCO_2 usually remains low. The patient with a normal or rising pCO_2 is in impending respiratory failure and may need a tracheostomy.⁹

The treatment of epiglottitis appears to be entirely different. Here, the variability of the disease makes early intervention essential. Specific antimicrobial therapy (ampicillin or chloramphenicol) is necessary but not sufficient. Because of the unpredictability of the disease, patients who appear in reasonable control one minute may have respiratory arrest the next. This has led to the general recommendation that all

children with the diagnosis of epiglottitis have their airway secured by one or another method.^{10,11}

The method of securing the airway has, until recently, also been a subject of dispute. Most individuals have recommended tracheostomy. It has now become apparent, however, that nasotracheal intubation, when performed by an experienced endoscopist, is a suitable alternative.^{12,13}

Conclusions

The following is a suggested scheme of management of patients with Croup Syndrome:

1. There should be a high index of suspicion for epiglottitis.
2. Each patient should have gentle inspection of the pharynx. The pharynx should be examined with the child in the sitting position (in Epiglottitis, the epiglottis becomes floppy and may completely obstruct the airway if the child is supine). If the epiglottis is not easily seen, and epiglottitis is strongly considered by history, then a lateral neck film must be obtained.
3. If the film is positive, then one should remember that this is an unpredictable disease, and that the assurance of an adequate airway is the physician's primary responsibility. Therefore, early elective tracheostomy or nasotracheal intubation should be performed on all patients confirmed of having this illness.
4. Epiglottitis is a curable disease and should have no mortality when diagnosed expertly and treated promptly.

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WRITE FOR LITERATURE AND SAMPLES

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Students in the biology classes of a local high school participated in a cardiovascular nutrition education program. The program will be evaluated to determine whether an educational intervention can affect students' knowledge, attitudes, reported dietary behavior, and serum lipid levels. This paper reports baseline data. The typical student knew relatively little about nutrition and heart disease. Cholesterol levels were distributed as would be expected based on national data for this age group. Seven individuals with cholesterol levels over 225 mg. per 100 ml. were found.

Cardiovascular Nutrition Knowledge and Lipid Levels Among New Jersey High School Students*

**Richard N. Podell, M.D.,
Kathryn Keller, M.S.W.,
and Gary Berger, M.D., Summit**

Successful lowering of blood cholesterol in free-living adults¹⁻⁶ and in adolescents in institutional settings⁷ have been demonstrated. However, it has never been demonstrated whether adolescents in an unrestricted situation will accept and maintain a cholesterol-lowering diet. This is unfortunate since adolescence is an appropriate time to establish practices aimed at preventing coronary disease. By the end of adolescence, environmental factors associated with heart disease are operating and often adult patterns of eating have already been established.

To test whether adolescents can be influenced in their dietary habits, Overlook Family Practice Residency Program, with the aid of the American Heart Association, has set up a program of cardiovascular nutrition education in the biology classes of a local high school. The study will determine whether the educational intervention affected the students' knowledge, attitudes, reported diet habits, and blood lipid levels. The present communication reports baseline data on the study population. To our best knowledge this is the first population-based survey of the lipid levels and cardiovascular knowledge and attitudes of New Jersey teenagers.

Method

The subjects are tenth-grade biology students from two local high schools. The overwhelming

majority are white and come from middle-income families. Students at one school, the study school, are receiving a program of cardiovascular health education. The program includes classroom instruction, student-sponsored discussion groups, and free diet counseling for students and their families. Students at the other school serve as the control.

Before the program began, a survey of all biology students at the study school was conducted. The students filled out a ten-page questionnaire which consisted of three parts: (a) a section on heart disease and nutrition knowledge, (b) a section on reported dietary behavior, and (c) a section on attitudes. The questionnaire also asked whether the student had anyone in his family who had heart disease or a high cholesterol level. Students at the control school were not surveyed. Students at the study school will be resurveyed in a year to note changes in the above aspects.

At the time of the questionnaire, students at both schools were tested for fasting cholesterol and triglyceride levels. In order for the student to have a blood sample drawn, parental permission was required. The Lipid Research Laboratory of the College of Medicine and Dentistry of New Jersey analyzed the serum samples, using the Technicon Autoanalyzer II® cholesterol and triglyceride extract method.

Letters interpreting the results were sent to the

*This study is from the Department of Medical Education, Overlook Hospital, Summit

families of student donors. Percentile ranks for cholesterol levels (based on national data for 16-year-olds) were employed instead of absolute values. Absolute values could be obtained by the student's family physician. If the student's lipid levels were elevated, the letter suggested that his parents consult their family physician for advice about possibly modifying their child's diet. In a year (to avoid seasonal variation) students will be retested to determine if their lipid levels have changed.

Results

The questionnaire was administered to the 377 biology students of the study school. This represents 98 percent of the biology classes (generally 10th grade) at the study school. The typical student did not know a great deal about nutrition and heart disease. The average student (using the median) was able to answer correctly four of the seven questions on heart disease and ten of the twenty questions on nutrition. It should be considered that some students undoubtedly guessed and thus the percent of students who actually knew the correct answers is somewhat less.

About fifty percent answered correctly when asked to identify heart disease as the leading cause of death among middle-age Americans from among five choices. More than three-quarters of the respondents were able to identify cigarette smoking as a coronary risk factor. Fewer students identified hypertension (sixty-seven percent) and blood cholesterol (sixty-four percent) as coronary risk factors. However, only fifteen percent of the students correctly identified a high carbohydrate diet and a low vitamin E level as not being risk factors for heart disease.

About three-quarters correctly answered that serum cholesterol would be raised by dietary cholesterol. However, students were less sure about the direction dietary saturated fats, polyunsaturated fats, alcoholic beverages, and vitamin C would have on serum cholesterol.

Students were asked to identify the low cholesterol, low saturated fat choice from among eleven food pairs. Over three-quarters of the students correctly chose margarine (vs. butter) and skim milk (vs. whole milk). About

seventy percent chose tuna fish as opposed to a hamburger. Between forty and sixty percent of the students correctly chose the low cholesterol food from the other paired choices.

Very few students (thirty-seven percent) knew that cholesterol is found only in foods of animal origin. Only eight percent knew that saturated fat is not a type of cholesterol. Only seven percent knew the chemical structure of polyunsaturated fats. (Table 1)

Table 1
*Knowledge Section — Study School Students
Percent Answering Correctly*

Questions	Percent Correct
Leading cause of death among American adults between 40 and 50	49
Proportion of American men who have had heart disease or heart attack before 65	30
Mortality rate from heart disease (as compared to Americans) for Japanese ages 45-54	51
Risk factor of blood cholesterol to heart disease	64
Risk factor of hypertension to heart disease	67
Risk factor of low vitamin E level to heart disease	14
Risk factor of high carbohydrate diet to heart disease	10
Risk factor of cigarette smoking to heart disease	78
Direction (raise, lower, not affected) blood cholesterol is affected by cholesterol in diet	72
Direction blood cholesterol is affected by saturated fat in the diet	54
Direction blood cholesterol is affected by polyunsaturated fat in the diet	43
Direction blood cholesterol is affected by alcoholic beverages in the diet	21
Direction blood cholesterol is affected by vitamin C in the diet	47
Best food for cholesterol-lowering diet — pork vs. veal	62
Best food for cholesterol-lowering diet — turkey vs. steak	51
Best food for cholesterol-lowering diet — whole milk vs. skim milk	78
Best food for cholesterol-lowering diet — coconut oil vs. corn oil	40

Best food for cholesterol-lowering diet — <i>tuna fish</i> vs. hamburger	69
Best food for cholesterol-lowering diet — ice cream vs. <i>onion roll</i>	46
Best food for cholesterol-lowering diet — butter or <i>margarine</i>	78
Best food for cholesterol-lowering diet — <i>rice</i> vs. hot dog	51
Best food for cholesterol-lowering diet — egg yolk vs. <i>egg white</i>	47
Best food for cholesterol-lowering diet — pot roast vs. <i>chicken</i>	54
Best food for cholesterol-lowering diet — egg vs. <i>potato</i>	60
What type foods (<i>animal</i> or plant) contain cholesterol	39
Saturated fat is not a type of cholesterol	8
Polyunsaturated fat is fat with several double bonds between the carbon atoms	7

Five percent of students said they make a major effort to limit cholesterol and saturated fat in their diet. Thirty-one percent said they made a modest effort. Furthermore, forty-seven percent said someone in their family eats a diet to lower cholesterol. Certain of the students' reported dietary practices are acceptable to a low cholesterol diet. Three-fourths of the respondents said they eat three or less eggs a week. However, few had ever tried egg substitutes. The majority of respondents said they use margarine in their diets; thirty-seven percent said they use margarine exclusively.

Other reported eating habits are not in line with recommendations for a low cholesterol eating style. The majority of respondents said they eat chicken or turkey for lunch or supper once a week at the most. Likewise eighty-five percent said they eat fish once or less a week. The majority of the students drank whole milk rather than skim or low-fat milk.

Eighty percent of the respondents said they do not smoke. Of the twenty percent who did report smoking, ten percent said they smoke less than a half pack a day.

As a surrogate measure of health concern, behavior related to vitamin supplements was

solicited. About half the respondents said they never take vitamins. Approximately twenty-five percent said they take vitamins between five and seven times a week.

Seventy-one percent of students felt their style of eating was satisfactory. When asked how they felt about a low cholesterol eating style, the majority of respondents said they did not know. Twenty-three percent said they felt a low cholesterol eating style was a little less attractive than a regular eating style. (Table 2)

Table 2
Reported Dietary Behavior and Attitudes
Study School Students

Question	Percent
Do you currently make any attempt to eat so as to keep your blood cholesterol down?	
Yes, a lot	5
Yes, a little	31
No	64
Does anyone living in your home try to eat foods to keep his or her cholesterol down?	
Yes	47
No	35
Don't know	18
How many whole eggs do you eat in a typical week?	
Three or less	74
Four to six	20
Seven or more	6
Do you eat low cholesterol egg substitutes (e.g. "Egg-Beaters")?	
Never tried	86
Tried but don't eat it anymore	8
Eat it, but once a week or less	5
Two to three times a week	1
Four or more times a week	0
How much milk do you drink?	
Drink one glass a week or less	9
Drink more than 1 glass/week, usually whole milk	55
Drink more than 1 glass/week, usually skim or low-fat milk	19
Drink more than 1 glass/week — both whole and skim/low-fat	16
How many times in a typical week do you eat chicken or turkey for lunch or supper?	
One or less	61
Two or three	36
Four or more	2
How many times in a typical week do you eat fish for lunch or supper?	
One or less	85
Two or three	13
Four or more	1

Do you eat —	
Margarine almost always	37
Margarine usually, butter occasionally	20
Butter usually, margarine occasionally	17
Butter almost always	25
Do you smoke cigarettes regularly?	
No	80
Yes, less than ½ pack per day	10
Yes, ½ to 1 pack per day	6
Yes, 1 pack per day to 1½ packs per day	3
More than 1½ packs per day	.3
Do you take vitamins — how many times a week?	
Never	47
Less than twice a week	16
Two to four times a week	12
Five to seven times a week	24
How do you feel about a low cholesterol eating style?	
Impossibly unattractive	5
Moderately less attractive than regular eating	17
A little less attractive than regular eating	23
As attractive or better than regular eating	9
Don't know	45
I feel that the way I eat now is:	
Pretty good	71
Not so good	23
Don't know	5

There were no striking differences between males and females or between those with a positive or negative family history of coronary disease/high cholesterol in predicting knowledge, attitudes, or reported dietary behavior.

At the study school 285 serum samples were drawn. A greater percentage (eighty-one percent) of males with a positive family history of heart disease/high cholesterol than any other group had their cholesterol tested. However, the differences among the groups were not statistically significant. (χ^2 was used).

The samples were analyzed for cholesterol and triglyceride levels. There were relatively few triglyceride elevations suggesting that students did fast as instructed. However, seven individuals with cholesterol levels over 225 mg. per 100 ml. were found.

Cholesterol levels were distributed as would be expected based on national data for this age group. Cholesterol levels ranged from eighty-one to 339. The median for the study group (157) was slightly lower than the national median for

this age (Approximately 168 mg. per 100 ml.)

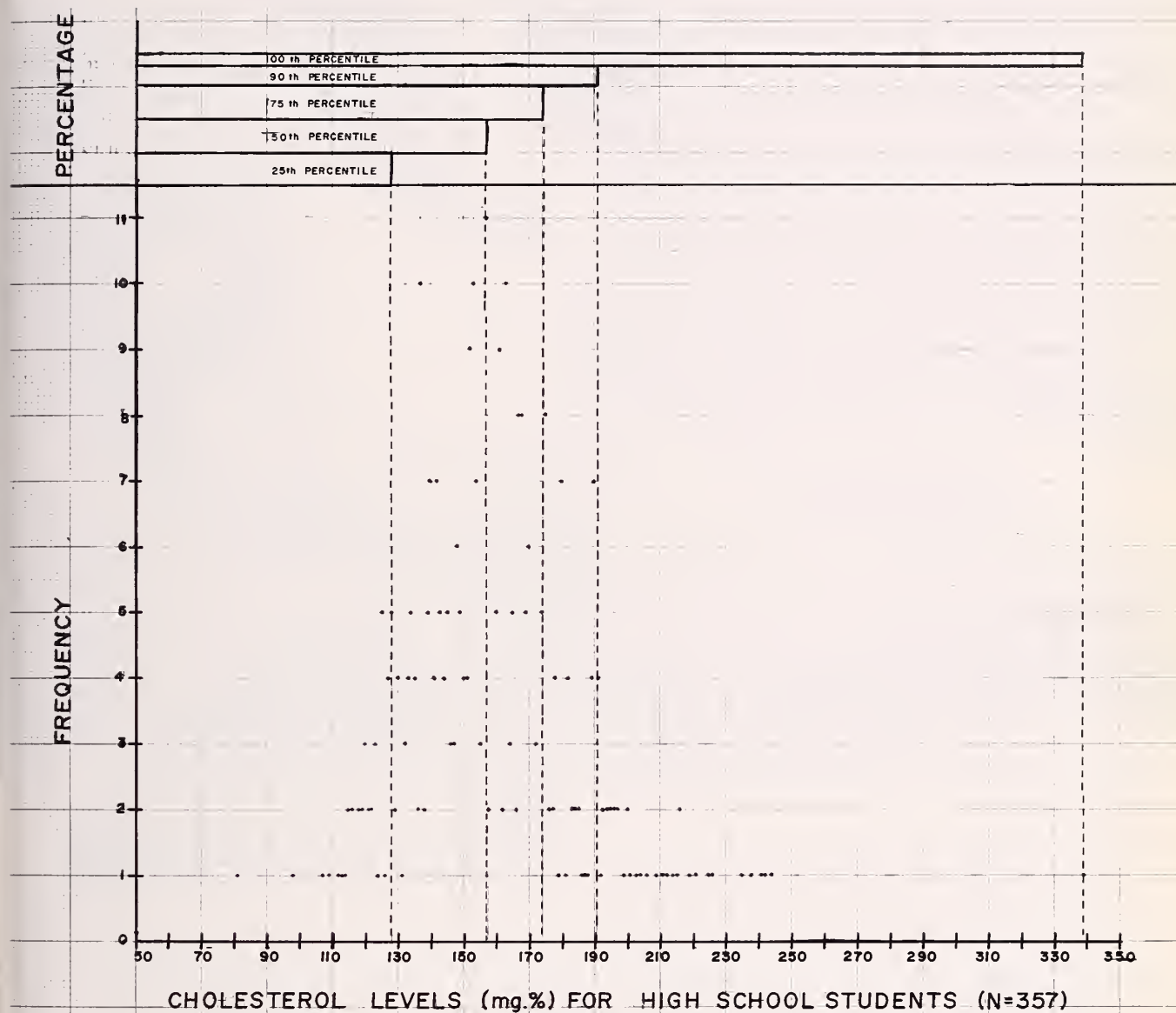
Blood samples were analyzed for cholesterol and triglyceride on about forty-six percent of the potential control group. As with the study school, there were few individuals of the control group with elevated triglyceride. Cholesterol levels ranged from 107 to 244 with the median at 160 mg. per 100 ml. (See Figure 1)

Discussion

Although the typical student was not highly knowledgeable about coronary disease and nutrition, the majority knew certain, specific facts. More than three-quarters of the students were able to identify cigarette smoking as a coronary risk factor. In identifying low cholesterol foods, over three-quarters chose margarine and skim milk. Seventy percent chose tuna fish as opposed to a hamburger. However, identification of other items was no better than might be expected by guessing. One wonders if mass media is not responsible for this pattern of knowledge. Radio and television have run public messages explaining the hazards of smoking. Brands of margarine are often advertised on the fact that they are low in cholesterol. However, most low cholesterol, low saturated fat foods, e.g., chicken, fish have not been permitted to be advertised in this context.

The students' reported dietary behavior reflects somewhat their knowledge. The majority of students said they use margarine in their diets, thirty-seven percent said they use margarine exclusively. Moreover, eighty percent of the students said they do not smoke. Most impressively, the majority of students had no opinion as to the desirability of low cholesterol eating, suggesting that there is indeed a need for a school curriculum in cardiovascular nutrition education.

The study demonstrates that large scale cholesterol screening of high school students is possible with minimal difficulty. We analyzed 361 blood samples from students. Four percent of the students (sixteen students) were in the top ten percentile of cholesterol nationally for their age. Three percent had elevated blood cholesterol by adult standards (220 mg. per 100 ml.)⁸



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An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated.

Gastric emptying may be useful in removing unabsorbed drug.

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Forty-six percent of those receiving their first medical licenses in 1972 were foreign trained. Many of these were native born Americans who studied abroad. In this paper, we examine, albeit briefly, some of the problems encountered by these graduates as they study abroad, and again when they come home. We also try to clarify some misconceptions about foreign medical education.

A Look at Foreign Medical Education and the Americans Who Undertake It

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William J. Annitto, M.D./New York*

In 1972, fully 46 percent of those receiving their first licenses to practice medicine in the U.S. were foreign trained.¹ It is not surprising then that so much has been written about foreign medical education, and foreign medical graduates (F.M.G.'s). Less has been written of those United States citizens studying abroad and little of that has been sympathetic. Perhaps this is because, relatively speaking, their numbers are not so great. Of the almost 4,000 physicians who took the ECFMG in the United States in January 1973, fewer than 250 (6 percent) were United States citizens at the time they started medical school.²

Having undergone that process known as "foreign medical education" the authors feel that they are equipped to clarify some of the current misapprehensions in this country about medical schools abroad.

Those Who Go

According to reliable sources^{3,4} there are many more "qualified" applicants to American** medical schools than there are available places. The ratio approximates 3 to 1, if one considers "qualified" those students having degrees from accredited colleges and universities, who have also completed the "basic requirements" (4 semesters of chemistry through organic, 2 of biology, and 2 of physics).

It should be noted that some authors may take

serious exception to our definition of "qualified."^{5,6}

The competition for those places gives every indication of becoming even sharper in coming years, given the "de Funis case" overtones that admissions to graduate schools have taken on. In short, minorities and majorities in ever-increasing numbers will be struggling to gain admission to American medical schools. This means that some 25,000 or more qualified applicants are and, more importantly, will be refused entry in United States or Canadian schools.

What do these "victims" of admission committees' obsession with grade point averages (GPA's) and medical college admission tests (Med-Cats) do? There are a number of alternatives open. Many students, the largest group, simply give up (we know one teaching high-school biology in North Carolina). Some swallow their intellectual pride and settle for dental school. Others, regrettably, continue in graduate school, and then, secure in their PhD's in biology or chemistry, become members of college pre-medical recommendation committees and dictate to aspiring young pre-meds. Still others choose the socially less-gratifying

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**American here refers also to Canadian Medical Schools which are members of the AAMC and whose graduates are thus not considered foreign.

(yet no less tortuous) path of osteopathy. The remaining go abroad and participate in "foreign medical education." According to Bramford⁷ more than 2,000 Americans enroll in foreign medical schools each year.

This last group — the students who go abroad — may be more finely subdivided. The first and largest single subgroup, perhaps 90 percent are virtually identical twins of the students who "made it" into American schools. They are the classic model of the medical student: highly motivated, goal-directed, middle class, neophyte scientists whom, for whatever reasons, the vicissitudes of the selection process (the addition of G.P.A.'s + Med-Cats multiplied by a constant for personality) selected "out." The second sub-group in foreign medical schools are those who majored in something other than pre-med, i.e., English literature, geography, and so on. They generally fulfilled the aforementioned basic requirements of the AAMC. They represent the "Renaissance man" so highly sought after by modern medical schools. However, most American schools still pay strict homage to the Philistines of a sterile technocracy.

A third subgroup is quickly disappearing. During the sixties, when only medicine, dentistry, and God warranted draft deferments, there was a surge of interest in foreign medical schools. This and the fourth subgroup are the most heterogeneous of the Americans abroad. They comprise highly motivated humanists, well-to-do dilettantes, freaks-on-holiday, and even an occasional opera singer-turned-scientist. The fourth subgroup are those who bypassed any pre-med course, not to say major subjects and, after attempting one career from pharmacist to vacuum cleaner salesman to New York City detective, decided that medicine was for them. They are generally the older, more staid members of any American colony. With family in tow, they certainly perform above average with perhaps more visible, motivating factors.

It is not uncommon for some of these students to have advanced degrees in other disciplines. Of the 30-some Americans who studied in Geneva with one of the authors (JHS), three had American doctoral degrees, one in physical chemistry, one in microbiology, and one in den-

tistry. Two of these students were in their late thirties and both had been told by at least one American medical school that they were simply "too old" for admission.

The Schools

When discussing foreign schools, those of Europe come immediately to mind. However, one will find Americans studying in all corners of the globe. Foreign schools, for convenience, may be divided into three geographic groups.

The European schools comprise the largest and most diverse group. Their diversity stems from many factors, not the least of which is the quality of the education. They do not have the same strict American accreditation regulations. They depend much more on attrition during medical school than admission committees to clear the "dead wood." More will be said of this in the section on problems. Some European schools compare very favorably in final product with American schools: schools in England, Sweden, Switzerland, Germany and some in Italy could fit into this category. Others, notably Spain, most French, and some Italian schools vary from quasi-par to strikingly below-par. Their government economies simply cannot expend the millions needed to alleviate the difficult conditions of overcrowding, ramshackle buildings, and antiquated curricula.

European schools do have several features in common. They are virtually all undergraduate programs of state universities. Local students go from their equivalent of high-school directly to medical school. Our pre-med is generally their first year of a five to seven-year medicine course. In fact, many European schools recognize this difference and allow Americans to begin in the second year (Rome and Switzerland for example). Other schools allow Americans to take an examination which, if passed, qualifies them for advanced standing (Belgium). A second point relates to the fact that these schools are under the financial aegis of their national governments regarding tuition. All European schools are much less costly to students than American schools. Tuition, in most, ranges from \$50 to \$250 per year, including laboratories but not books.

Finally, all schools teach and give examinations in the native language. Unfortunately, the English-speaking schools in Ireland and the United Kingdom (Northern Ireland, England, Scotland, and Wales) are the most difficult to enter. The United Kingdom has a centralized admitting office in London which maintains a two-year waiting list (as of 1968). In the Republic of Ireland, there is a competitive examination with an approximate ratio of 300:1 for examinees to places available.

The second group of schools is in Asia. For Americans, this primarily means the Philippines. These schools, the University of the East, the Far Eastern University, and the University of St. Tomas, are patterned after American schools. They are four-year programs, taught in English with American texts, and have many exchange professors from the United States. Until the late 1950's these schools were considered on a par with American medical schools. At variance with most of the European schools is the fact that competition for places is very stiff — given the language, the length of the program, and cost. Tuition is only slightly higher than European rates — about \$400 per year — but the airfare may be prohibitively high.

Australia, which has seven schools, has virtually no Americans presently enrolled. It would offer the persevering American who first passed a competitive state entrance examination excellent clinical training. However, the first year attrition rate is upward of 30 percent and at completion (6 years) approximates 50 percent of the entering class of 400.

The third major group of schools having substantial numbers of Americans is in Latin America. Without question the largest number are at the Autonomous University of Guadalajara, which in point of fact, has the highest enrollment of American medical students of any medical school in the world.⁸ We view this as a sad fact, since, both academically and culturally, it does not deserve such a vast population of future American physicians. There are three main reasons for its success:

(1) It is a four year program; (2) it is not overseas; one can drive there; and (3) its admis-

sion standards have been minimal. Concerning this third point, we quote Dr. J. R. Santos, Dean of the Medical School, "Our doors are open to all — we ask only that the student is (sic) motivated and wants (sic) to study medicine more than anything else."⁹

It has several drawbacks, however, that we consider serious. First the apparent four-year course is actually a five-year program, with the last year being a year of required clerkships in the fifth channel or fifth pathway program.¹⁰ Second, the tuition of \$2,500 per semester at Guadalajara is exorbitant (and possibly the limiting admission factor). Third and most importantly, the quality of medical education seems to be relatively poor and, therefore, inconsistent with the large enrollment. Most former students interviewed concurred on this point, especially as related to their personal performance on standardized American examinations (National Boards, ECFMG, and so on). Fourth, the quality of life was felt to be detrimental to effective study. This is in no way meant to denigrate all Mexican culture. However, most Americans felt they were resented and misunderstood. These were far and away the leading complaints against the Mexican educational system. In this vein, another comment by Dr. Santos may be illuminating: "We have no room for long hair, bearded students, radicals or flunk-outs."⁸

The Methods

Given the diversity among the students who go to foreign schools, and the diversity among the schools themselves, the routes or methods the students employ to gain admission vary accordingly.

Perhaps the most common pathway, and that which should be most obvious, is directly *via* the consulate of the given country. In his senior year of college, after having received the last "dear John" letter, our undaunted American picks up the phone and calls, say, the Italian consulate on Park Avenue in New York City. He is mailed application forms or advised to come in directly to start processing. This direct method is perhaps the easiest, but definitely the most bureaucratic, since it involves inherent risks, i.e., one may easily become lost in the shuffle.

The second and increasingly popular method was recently surveyed by one of the authors (JHS). Reading *The New York Times* — Sunday edition — one can find half a dozen agencies which offer placement to Americans in foreign medical schools. Posing as a student with a B average overall and mid-five hundreds on the Medical College admission test, this author called five of the services. One agency required only name and address and would forward the necessary information. Another gave immediate assurance that a place awaited in a Mexican school (not Guadalajara). A third, only representing one of the few private medical schools in France, promised nothing, but sent rather elaborate brochures which appeared to be very straight forward. This was the most expensive.

Prices in general for these services ranged from a low of \$500 to a high of \$4,000. This latter offer, albeit exorbitant, seemed to guarantee a good chance of admission into an acceptable school.

The authors have no other experience with any of these organizations and though they may minimize red tape and maximize opportunity: *Caveat Emptor!*

A third method, the most aggressive, is a frontal assault on the desired medical school. With all necessary documents in hand, the aspiring medical student goes directly to the schools and seeks admission. Europe offers the best opportunity here, as airfare is much less than to the Far East and, once there, all the countries are available *via* car or rail. However, even though a particular dean may be impressed with the student's great motivation and adventurous spirit, he may be restricted by national regulations governing admissions. For example, in the United Kingdom whatever "extra" places are available are saved for students from Commonwealth countries, of which the United States is not a member due to that unfortunate incident in 1776. Many countries, moreover, have delegated admission authority to their respective consuls (such as Italy, which paradoxically and in typically Italian fashion, would also accept someone who presented himself in person!).

The Problems

Though the problems encountered by the

students once they begin to live and study in a foreign country are as extraordinary as the students themselves, certain broad categories can be distinguished.

Language and Culture — With few exceptions, Americans will be studying in a new and often totally unfamiliar language. Simultaneously, the culture which subtends this language will be at once new and alien, yet vaguely familiar. We do not pretend that we can formulate the psychological make-up of an ideal imaginary student. We do feel, however, that the success with which a student accommodates to his new environment is a function of his personality and psychological stability. Furthermore, we believe that the attitude with which the student accepts his "foreign lot" will determine whether his experience will be pleasant and maturing (as well as educational) or grimly unpleasant, and reinforcing of an immature bitterness at his fate.

At this juncture, personal anecdotes might be somewhat informative. One of us (WA) studied for four years in Bologna, Italy, before transferring to the New Jersey Medical School of the College of Medicine and Dentistry of New Jersey. By means of identification with the aggressor (if one would speak of defense mechanisms), he became fluent in Italian well before the beginning of the first examination period through the simple expedience of effort. Having learned "street" Italian in the cafes, it was not too difficult a transition to text book or "formal" Italian. Moreover, once the first text had been translated (painfully slowly), the others became readable in short order. Culturally, Bologna is a city suited to anyone who enjoys good food, leisure, and antique architecture; all are in abundance.

The other author (JHS) had no pre-medical background and no knowledge of any foreign language. He chose the present-onself-in-person-route and it worked. He was accepted into the University of Geneva, Switzerland, where he did all his pre-medical sciences. He remained in Switzerland during the summers, worked in the University Hospital, and did "odd jobs." This gave him the necessary fluency in French. Later, he was able to do translations and teach English for a Swiss bank and thus became almost self-supporting. For the most part, he

used English texts and then at the time of the examinations (which were oral) translated into French on the spot. This may not be the best procedure, but it did work. Culturally, Geneva is a rewarding city. It is the European headquarters of the United Nations, and is broadly international in tone, with people from every part of the world. These were two of the most exciting and rewarding experiences imaginable.

Philosophy of Education — In European schools, medicine is taught in a manner decidedly different from the American system. Ours is a system aimed at producing students who are all basically at the same level at the same time. Conversely, European schools offer a marked diversity of philosophies. In Italy, the student advances at his own pace. He becomes eligible for further exams each May as classes for a given level end. A student may take only one oral examination in June, one in July, and one each in October and December, and still remain "on time" toward his graduation.

France, on the other hand, is more regimented than most. At the end of each school year, the student is confronted with all his written examinations on one day. Needless to say, the attrition rate for students is very high there compared to Italy. It has been reported¹¹ that the attrition rate for Americans studying in France approaches 90 percent.

In Switzerland, at the end of a teaching cycle (which may be two, three, or more semesters) examinations are usually administered orally. The student must obtain a minimum score on each examination or he must repeat the whole set, usually waiting six months until the set is given again.

Miscellaneous — There are many other problems that may affect the individual. In Italy, for example, facilities are far below those to which we are accustomed in the United States in both quality and quantity. Laboratories are few and, in general, attendance is not required. Lecture halls are jammed in Bologna: approximately 400 to 600 students attend anatomy lectures in a hall built to accommodate 250 to 300. According to the dean of the University of Rome Medical School,¹² the facilities there were

designed for 6,000 students; there are 12,000 students. He admits that the quality of education suffers accordingly.

Oral exams offer peculiar stresses to Americans who have been spoon-fed on multiple-guess-type tests.

Registration in Italy, a country where there are "lines" on the streets for pedestrian safety, is an experience in group dynamics not to be missed.

Attrition — In America, there is virtually no attrition between the first year of medical school and graduation. Ninety percent of those accepted will finally graduate. In Europe, the attrition rates tend to be inversely proportional to the facility of admission. In France, as has been mentioned, the attrition rate is phenomenal while admission is virtually open to anyone. In Switzerland, all Swiss nationals with a high-school diploma, and a desire to do so, must be allowed to start medical school. The attrition rate is much lower, though many fail at least one set of examinations and extend their time accordingly. In Italy also, the attrition rate is very high (60 percent). This all adds up to an additional stress for the student who is working hard and spending money with no assurance that he will finally graduate.

Another problem is the question of coming back to the United States. We do not intend to discuss this here in any detail for two reasons: (1) the rules are in flux and (2) it depends on when one comes back: either as a transfer student to complete medical training in the United States (as the authors did) or after completing training abroad. Anyone interested in the latest rules should get the current edition of the AMA's Directory of Approved Internships and Residencies, commonly called the "green book." This contains all necessary information, presented in an almost comprehensible form.

One should note that all foreign medical graduates (FMG's), be they U.S. citizens or aliens, must first pass the examination given by the ECFMG, in order to start an internship in virtually any AMA approved program. This obstacle must be overcome or the whole study effort is for nothing. It, therefore, behooves the

student contemplating study abroad to acquaint himself with a few essential facts. First, that the pass-rate of the ECFMG exam varies widely from country to country (United Kingdom, 94% to Philippines, 23%).¹³ Second, this does not appear to be a function of language, as both the above countries teach in English. Moreover, the passing rate for United States citizens in a country does differ significantly from the natives of that country. Before making a final choice, one should find out how the schools in which he is interested do on this examination. It is not important what the examination measures or purports to measure,¹⁵ it is only important that it is there.

Discussion

Because of the conditions that obtain in this country regarding medical education, many "qualified" Americans, motivated to become practitioners of the second oldest profession, will continue to go abroad for their education. It costs more than \$50,000 to train a physician in this country.¹⁶ Therefore, these schools offer a substantial service in foreign aid to this country to help fulfill our health care needs. In light of all this, we feel that these schools ought to be viewed more sympathetically.

We feel that foreign medical education represents a viable alternative to the domestic variety, despite its inherent problems.

We have attempted to describe, albeit briefly, those types of students who go abroad, and to put to rest the myth that they are *ipso facto* inferior to their more stationary peers. We are fully aware that there is a certain "stigma" attached to having a foreign medical degree. The reasoning goes: (1) they were rejected by American schools, (2) they were accepted by foreign schools, therefore (3) the foreign schools are inferior to the American schools because they attract inferior students.

We believe this may be the case, but it is not automatically so. There are open admissions in many undergraduate schools in American universities. This does not lead to automatic graduation, nor does it mean poor quality education. It must be remembered that medicine is an undergraduate program in virtually all countries except the United States and Canada. Many

foreign schools, like American universities with open admissions, have high attrition rates. The final product, however, may be comparable to the American one.

There are data which show that FMG's as a group are disadvantaged with respect to finding internships and residencies.¹⁷ They tend to get the "leftovers" that are not filled by American graduates.

We have also surveyed those areas where large numbers of Americans go for their training. Moreover, we have given a summary of the pathways by which these students matriculate at some of these schools.

In discussing foreign schools we have attempted to be both factual (i.e., costs and logistical problems) as well as critical. We admit that their cumulative "problems" may be a cause of the greater range of fluctuation in quality relative to our more stringently quality-controlled American schools. However, we defend the concept that exceptional faculties of medicine do flourish outside the sometimes provincial borders of the United States.

We have pointed out, *via* our own experiences, some of the other less tangible rewards of study abroad. These include (among many others) travel, learning a new language, living in, and perhaps coming to understand a new culture, new friends, and perhaps most gratifying of all, the fact of accomplishing a major goal against imposing odds.

The reader may ask himself, if it was so wonderful "over there" why did the authors transfer back to an American school? We did so for many reasons. We suffered from that vague feeling of "inferiority." We believed that American medical education was better (not necessarily so). One author (JHS) saved a year by transferring. We avoided the "stigma" of the foreign degree and the hassle (ECFMG, and so on) of coming back as FMG's.

For the student who cannot get into an American school, regardless of the reasons, we recommend that he consider going abroad. It was right for us. It was a very positive experience and we would do it all over again tomorrow.

Editor's Note: We cannot always vouch for the point at which fact and opinion separate, so *caveat reader!*

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CASE REPORTS

A meat-carcass handler developed patches of hyperpigmentation on the chest and abdomen after traumatic penetration of his skin by protruding carcass bones. Review of published occupational marks, trauma, and tattoos revealed no such previous case. Trauma ranks second in frequency as an etiologic agent in occupational dermatologic disease, but data is scarce in published analyses of hazards to butchers, packing-house workers, and slaughter-house workers. The patient in this report refused skin biopsy, but the pigment was almost certainly melanin.

Occupational Hyper-Pigmentation Via Beef-Carcass Tattoo

Report and Review

**Melvin Hershkowitz, M.D. and
Narendranath A. Reddy, M.D.
Jersey City***

Internists and dermatologists have long been interested in the skin as a reflection of systemic disease.¹⁻⁵ Jeghers' review of skin pigmentation and its variations in health and disease,⁶ the first modern synthesis of the subject, showed that pigmentary changes may suggest the intrinsic nature of an illness, may precede other organ involvement, and may have prognostic value.

The skin may also reflect occupational hazards, drug toxicity and intolerance, and trauma.⁷⁻⁹ This has long been recognized in non-medical literature, wherein such exemplary astute observers as the Holmes brothers, Sherlock and Mycroft, could predict an individual's geographic origin, life style, social position, and occupation by inspection of the skin and external bodily markings.¹⁰ Ronchese's book¹¹ on occupational identification by external skin markings contains illustrations of many bizarre pathognomonic occupational marks, but little on occupational tattoos.

Occupational tattoos may be classified as a subdivision of occupational marks. The dermatologic changes in tattoos are produced by deposition of foreign material beneath the skin, or by a process which elicits production of abnormal amounts of pigment in response to occupational trauma. The patient described in this report is an unusual example of the latter.

Case Report

A 52 year-old meat-carcass handler entered the Jersey City Medical Center on March 13, 1973 with congestive heart failure secondary to hypertension and chronic obstructive lung disease. He had taken digoxin and furosemide previously, but none for ten days before admission. His past history was negative for previous illnesses or operations. His family history was negative.

Physical examination on admission showed a normal temperature, a blood pressure of 140/90 mm Hg, a respiratory rate of 24/minute with dyspnea at rest, and an irregular cardiac rhythm with a ventricular rate of 100/minute. The jugular veins were engorged; the heart sounds were distant and of poor quality, and no murmurs were heard. The thorax showed an increased antero-posterior diameter with diminished respiratory excursions. Expiratory wheezes were audible over all lung fields. The abdomen was soft, the liver edge barely palpable and smooth but not tender, and the spleen was not felt. There were no other abdominal masses or areas of tenderness. All peripheral pulses were present, normal, and equal. There was bilateral pitting pedal edema. The neurological examination was normal. The remaining physical findings, except for the skin, were normal.

Laboratory data: the hematocrit was 43%, the hemoglobin 14 grams/100 cc, the white blood cell count 9700/mm³ with a normal differential. Urinalysis showed a specific gravity of 1.007 on a casual specimen, was normal on microscopy, and was negative for glucose, acetone, blood and protein. The blood urea nitrogen, creatinine and serum electrolytes were normal. The fasting blood sugar was 100 mgm/100 ml. Liver function tests were normal. The blood VDRL was negative. Sputum cultures and blood cultures were negative. A chest x-ray showed generalized cardiac enlargement. An electrocardiogram showed atrial fibrillation with a ventricular response of 100/minute.

During his stay in the hospital, the patient was treated with dietary sodium restriction and with digoxin, furosemide, aminophyllin, potassium chloride, and sodium secobarbital.

*From the Department of Medicine, Jersey City Medical Center where Dr. Hershkowitz is Associate Director, and Dr. Reddy is Chief Resident.

orally. On this regimen he showed excellent improvement, and was discharged eight days after admission for further ambulatory observation.

The skin showed changes unrelated to the patient's illness and treatment, but related to his work. Light brown macules, 1 to 2 cm in diameter and varying in shape, were scattered over the lower chest, upper abdomen, and right anterior and midaxillary lines. A horizontal light-brown macular streak, 4.5 cm long and 1 cm wide, was present 3 cm below and to the left of the umbilicus. (Figures 1,2,3)



Figure 1 — General distribution of pigmented areas on anterior chest and abdomen.



Figure 2 — Closer view of the individual pigmented areas on chest and abdomen.



Figure 3 — Pigmented areas in right anterior and mid-axillary lines.

Occupational history — From 1965 through 1968 the patient worked inside refrigerator trucks and railroad reefer cars as a handler of fresh and frozen beef carcasses. A carcass moving on its transmission hook would sometimes sway or fall off, penetrating the patient's clothes, piercing the skin of his chest or abdomen with the protruding bones. The pierced areas often bled, but the patient never treated himself while working. After work he washed with soap and water and put on a clean undershirt, but never applied iodine, or other local medications, or protective dressings. A thin crust formed over the penetrated areas within a few days after each incident, and later fell off. The pigmented areas described above were left behind. After 1968, the patient stopped this work and developed no new lesions.

Discussion

Trauma ranked second in etiologic frequency among eight major groups of occupational skin diseases described by Allen.¹² The introduction of metallic foreign bodies beneath the skin is probably the commonest event in penetrating occupational injuries,^{8,12} but traumatic tattoos may be produced by a variety of other foreign particles, including slate, gravel, common dirt, gunpowder and carbon.^{13,14} Drug addicts may introduce a diversity of foreign particles into their antecubital fossae and at other sites, leaving the characteristic "tracks" and other marks as a response to repeated traumatic and contaminated needle puncture. These well-known marks are composed of hemosiderin and giant cells deposited in response to local injury, as well as soot and other particles from "sterilized" needles.

The skin pigment produced and deposited in response to trauma is almost always melanin.^{15,16} This occurs without a concomitant increase in the number of melanoblasts, and the mechanism is not yet known, but may be related to a local increase in temperature and destruction of sulfhydryl groups.¹⁷ Thermal and chemical burns may destroy melanocytes and thus lessen rather than increase melanin production.¹⁸

In the twenty-five year interval between his book¹¹ and his most recent review,¹⁹ Ronchese reported no cases of traumatic tattoos in meat-carcass handlers, and the literature for the ten year period 1964-1973 yielded no specific information on this subject.

Adams reviewed dermatologic occupational risks in one hundred work categories.²⁰ Meat

workers had many reactions to antibiotics and detergent soaps, but not to trauma. Birmingham and Key, in an extensive review of varying occupations,⁹ listed nine provocative agents in slaughter-house and packing-house workers: antibiotics, bacteria, brine, cold, synthetic detergents, enzymes, fungi, parasites, and spices. Schwartz, *et al.*,⁸ studied the etiologic factors in occupational risks to butchers, slaughter-house workers, and packing-house workers, but did not include traumatic penetration of the skin by carcass bones. Workers who slaughter, prepare, and transport meat carcasses might be expected to have a high frequency of cutaneous trauma, but if this assumption is true, and if post-traumatic hyper-pigmentation of the skin has been observed, there have been few or no published reports on it.

It is possible, though improbable, that rough margins of the carcass bones carried blood, later reduced to hemosiderin, into the corium of our patient, thus producing the pigmentation. Statistically, however, it is highly probable that the pigment was melanin. The patient refused skin biopsy.

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A case of traumatic rupture of the right diaphragm is presented. All physicians seeing trauma patients must consider the diagnosis when viewing an abnormal admission chest x-ray. Diagnostic pneumoperitoneum was utilized for confirmation of the diagnosis and surgical correction was successfully instituted.

Pneumoperitoneum for the Diagnosis of Traumatic Rupture of the Right Hemidiaphragm

**Iradj Salahi, M.D.,
Malcolm Coblentz, M.D., and
Charles Abbott, Jr., M.D.
Livingston***

The presence of acute diaphragmatic laceration, secondary to blunt trauma can be easily missed. The lack of surgical diagnosis may be due to the physician's initial concern over other associated organ injuries as well as to the misinterpretation of admission chest x-rays. With the increased number of high speed motor vehicle accidents today, disruption of the diaphragm is becoming more common. This case presented is unusual in that rupture of the right diaphragm occurred whereas the vast majority of reported cases involve the left diaphragm in a ratio of 25:1.¹

Case Report

A thirty-one year old female was admitted to Saint Barnabas Medical Center on December 9, 1973, approximately one hour following a car accident. She was a front seat passenger and was not using a seat belt. The car struck a pole, turned over, and she was thrown out. There was no history of loss of consciousness except for a momentary lapse of memory. At the time of admission, she complained of dyspnea, chest pain, and right knee pain. On physical examination, the blood pressure was 120/90 mm Hg., the pulse rate 120/min. and the respiratory rate 48/min. There were several facial lacerations but no evidence of skull fracture. There were also ecchymoses and skin abrasions involving the right upper abdomen and right lower thorax. The chest was tender on the anterolateral aspect of the right hemi-thorax. Dullness to percussion and decreased breath sounds were present over the entire right lung. The abdomen was soft and peristalsis was present but hypoactive. There were no extremity fractures or dislocations.

A chest roentgenogram obtained at the time of admission revealed partial opacification of the right hemi-thorax and displacement of the mediastinum to the left (Figure A-1). The left lung was clear and there were no rib fractures.



Figure A-1 — Elevation of the right leaf of the diaphragm with right pleural effusion and mediastinal displacement to the left.

A chest tube was inserted and approximately 200 cc of blood removed. A repeat chest x-ray showed good position of the drainage tube. There was no evidence of pneumothorax or infiltrate in the lung fields; however, the right hemidiaphragm appeared to be elevated suggesting, in the

*This case report is from the Department of Surgery, Saint Barnabas Medical Center, Livingston, where Dr. Salahi is chief surgical resident, Dr. Coblentz is resident in surgery, and Dr. Abbott is attending in thoracic and cardiovascular surgery.

presence of trauma, the possibility of a ruptured right hemidiaphragm.

Since the patient had a right chest tube in place and did not have a bronchopleural fistula, it was elected to do a diagnostic pneumoperitoneum. The chest tube was momentarily clamped, 250 cc of air was introduced into the peritoneal cavity, a portable chest x-ray was immediately obtained and chest suction reinstituted. The immediate evacuation of air from the right chest demonstrated the presence of pleuroperitoneal communication and the chest x-ray confirmed the presence of a transient pneumothorax.

The diaphragm was repaired through a right posterolateral thoracotomy. Upon entering the right pleural cavity, the main bulk of the liver and the gallbladder were in the right hemi-thorax (Figure A-2). Examination of the liver revealed it to be intact except for some bruising over the superior and posterolateral surface. The liver was replaced into the abdominal cavity and a large tear in the right hemidiaphragm, extending from the area of the inferior pulmonary ligament anteriorly and laterally out to the rib cage, was seen. The diaphragm was closed with a figure-of-eight suture of #0 silk and reinforced with a second continuous row of #0 silk sutures.



Figure A-2 — Intra-operative findings showing displacement of the liver and gallbladder into the right chest.

Since this patient had been improving on nasogastric suction preoperatively and had good bowel sounds, the abdomen was not explored. Postoperatively the patient had a benign course and was discharged on the 10th postoperative day (Figure A-3).

Discussion

Diaphragmatic laceration is relatively common in patients sustaining multiple injuries. Ambrose Pare,² in 1840, first described diaphragmatic hernia following a gunshot wound of the diaphragm and until 1940 there were only a few cases of traumatic diaphragmatic rupture which had been recognized and treated. Recent articles have made reference to an increase in the incidence of closed non-penetrating traumatic diaphragmatic hernia primarily due to the frequency of high speed motor vehicle accidents or



Figure A-3 — Chest x-ray prior to discharge showing a normal diaphragm and clear costophrenic angles.

other crushing-type injuries.^{3, 4} Ebert¹ reported that traumatic hernia of the left diaphragm was 25 times more common than on the right. This is probably due to the buffering effect of the convex surface of the right lobe of the liver. The inadequacy of surgical diagnosis may be due, in part, to the critical general condition of the patient because of shock and other associated organ injuries, and to the relative infrequency of its reported incidence in the past. The mortality from missed or delayed diagnosis continues to be high. The overall mortality rate varies in reported series from 8 to 34 percent.^{5, 6}

Failing to consider the possibility of acute diaphragmatic injury while evaluating an abnormal chest roentgenogram after blunt trauma has been cited as the chief reason for error in diagnosis.⁷ Every physician who evaluates trauma patients should be alerted to this possibility when he encounters an "abnormally high diaphragm" on an admission chest x-ray. If, as with our patient, a chest tube is in place, an expedient and safe diagnostic method is the institution of a small pneumoperitoneum. This procedure should be done with portable x-ray guidance to allow rapid confirmation of the

diagnosis along with immediate reinstitution of chest suction so as to avoid any possible respiratory embarrassment.

This case demonstrates the application of these principles and the successful repair of an acute traumatic rupture of the right diaphragm.

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St. Barnabas Medical Center, Livingston

Pathology — Stanley Burrows, M.D.*

Therapy of Hypothyroidism:

The three tests of greatest value in determining the adequacy of hormone administration in hypothyroidism are: serum thyroid-stimulating hormone (TSH), tri-iodothyronine (T3) and T3 uptake. The most sensitive indicator of hypothyroidism is an elevated serum TSH, which may occur even in the presence of normal serum total and free thyroxine (T4) levels.¹ The administration of an adequate amount of thyroid hormone will cause a fall of the serum TSH to normal levels. Several investigators^{2,3} have reported that the treatment of hypothyroidism with just enough thyroxine to suppress the elevated serum TSH level produces normal serum T4 and T3 levels and that the patients become clinically euthyroid.

Eastman, *et al.*⁴ noted that most hypothyroid patients on T4 replacement therapy require larger oral doses of T4 than normally produced by the euthyroid patient, resulting in serum T4 levels under effective therapy that are commonly within the upper part of the normal range or slightly elevated. However, the serum T3 levels were above normal in only 8 percent of effectively treated hypothyroid patients and these elevations were slight and lower than those found in hyperthyroid patients. On this basis, they recommended the measurement of the serum T3 for the assessment of T4 replacement

therapy in hypothyroidism.

The maximal binding capacity of serum thyroxine binding globulin (TBG) and thyroxine binding pre-albumin is the same in hypothyroid as in euthyroid subjects, and the maximal binding capacity of serum TBG does not vary with thyroid function.⁵ Therefore, the measurement of the serum T3 uptake is reliable for the adjustment of drug therapy of hypothyroidism.

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*From "The Cooper Review" published by The Department of Medical Education, Cooper Medical Center, Camden, where Dr. Burrows is Chief Attending, Pathology Department.

BCG Revisited

Waymon C. Lattimore, M.D. and Lee B. Reichman, M.D., Newark*

We have read with interest the debate: BCG Not for Newark; BCG for Newark by Leon Smith, *et al.* in the June, 1975, *Journal*. Dr. Smith and colleagues have done the practicing physicians of the state a service by reviewing the often-conflicting and emotional reports and results pertaining to BCG which abound in the literature. As is apparent from review of the two articles, rational people can reach different conclusions from the same data.

Recently the Advisory Committee on Immunization Practices of the National Center for Disease Control, United States Public Health Service met and redrafted the official United States Public Health Service recommendations on BCG vaccine.¹ In the capacity as consultant to the Tuberculosis Control Division of the National Center for Disease Control, one of us (LBR), had the opportunity to participate in that meeting and help draft the new statement. Review of several factors led to the new statement which, although restrictive in suggested uses of BCG, is less so than the previous statement.² Conclusions of the committee, with regard to the use of BCG, were based on considerations which we feel will help the New Jersey medical community better understand why most health officials are still opposed to widespread use of this vaccine in the United States. These were:

1. There are numerous BCG vaccines available worldwide. All are derived from the original strain as described by Smith, *et al.*, but these do vary in reaction, immunologic effect, and efficacy. It must be remembered that the original vaccine was produced by repeated culture passages from a virulent strain of *M. Bovis*. Since the original vaccine there has been variation, probably as a result of genetic changes in the bacteria, as well as different production techniques.

All of the good, controlled clinical trials took place prior to 1955. The two vaccines licensed for use in the United States differ from those

used in the trials because of the many subsequent culture-passages and the modifications in the method of preparation and preservation of the vaccine. Since the original vaccine has been sub-cultured to lead to the products now available, and there have been no good field trials using the currently available and licensed liquid freeze-dried preparations, it must be concluded *that the efficacy of these current vaccines has not been demonstrated directly and can only be inferred.*

2. It often has been stated that BCG must be capable of inducing tuberculin-sensitivity in guinea pigs and humans, but the *assumed relationship between sensitivity and immunity has never been proved.*

3. As well outlined in the debate by Smith, *et al.* BCG has been associated with adverse reactions. These include prolonged, severe ulceration at the vaccination site, lymphadenitis, lupoid reactions, disseminated BCG infection, and death. These experiences, however, are mostly from foreign countries and do not necessarily pertain to the licensed United States vaccines. The reported frequency of complications has varied greatly.³ For example the rate of ulceration and lymphadenitis ranges from 1 to 10 percent and this appears to depend on the vaccine itself, its dosage, and the age of the recipient. BCG osteomyelitis was previously thought to occur in 0.1 per 100,000 vaccinations but recent confirmed reports indicate that the incidence among newborns in Scandinavian countries is 5 per 100,000 vaccinations, a considerable difference. (5 cases of BCG osteomyelitis per 100,000 is considerably higher than the new active tuberculosis case rate of this age group in Scandinavia or Newark).

4. One measure of the usefulness of BCG in a given population group is the number of cases

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prevented. In New York City, whose ghetto areas are very much like Newark's, there were 2,101 new active (Stage III in the new classification⁴) cases of tuberculosis in 1973. In Newark there were 226.

It has been said that BCG should be given to prevent the complications of childhood tuberculosis. In New York City, in 1973, the Stage III tuberculosis rate was 6.8 per 100,000 population in ages 0 to 15; in Newark in 1973, the Stage III case rate for ages 0 to 14 was 12.3 percent. Because of the smaller population this rate was caused by 5 cases from age 0-5 and 10 cases from 6-14, a total of only 14 cases in this age group. The decline of tuberculosis in children of United States cities has been steady even in the absence of the use of BCG. For some years Dr. Aaron D. Chaves, formerly Assistant Commissioner of Health in New York City, has compared rates of decline for childhood tuberculosis in a country where BCG has been in general use (Hungary) with New York City where there has been very little use of BCG and found no difference in these rates. Newark has experienced a similar, though less precipitous decline in the Stage III tuberculosis case rate.

From age 0-9 where most of the damage would be expected to occur, in 1973, in New York City there was only one case of miliary tuberculosis and one case of tuberculous meningitis. (Table 1) These are the life-threatening, worrisome conditions one would hope to prevent by the use of

BCG. A good epidemiologist will require a denominator; for this age group in New York City it is 1,247,578 citywide; in Newark it is 82,984 citywide. If, as is likely, these cases come from non-whites or Puerto Ricans, many of whom live under crowded conditions in ghetto areas, the denominator would shrink, but it would still be 401,173 in New York. (A similar ethnic breakdown is not available for Newark). Table 1 gives the entire picture of childhood tuberculosis in New York City for the past five years; Table 2 displays similar data for Newark for the same period.

Besides looking at the benefits of a BCG program in preventing disease, the overall magnitude of the tuberculosis problem should be considered and this is best done by considering the infection rate. The prevalence of infection can be gleaned from tuberculin testing statistics at New York's child health stations, most of which are in ghetto areas. In 1973, children ages 0 to 6 made up 0.39 percent of 77,358 positive skin tests.

Smith, *et al.* state that from July to September (year not stated) there were 201 patients hospitalized for tuberculosis in Newark and 1487 non-hospitalized patients suffering from the same disease. These figures are not reflective of the official morbidity reports disseminated by the New Jersey State Health Department. (Table 3)

Table 1

Newly Reported Cases of Tuberculosis — Age 0-9 New York City — 1969-1973

Years	Pulmonary	Miliary	TB of Pleura	Meningitis	Genito-Urinary	Lymph Nodes	Other Forms	Total
1969	155	1	2	6		15	2	181
1970	122	1		11	1	9	2	146
1971	160	4		4		7	3	178
1972	114	2	2	1		3	1	123
1973	89	1	2	1		9	4	106

Table 2

Newly Reported Cases of Tuberculosis — Age 0-9 Newark, New Jersey — 1969-1973

Year	Pulmonary	Miliary	TB of Pleura	Meningitis	Genito-Urinary	Lymph Nodes	Other	Total
1969	13	0	3	0	0	0	1	17
1970	17	0	0	0	0	1	0	18
1971	11	0	0	0	0	0	0	11
1972	10	0	1	1	0	3	0	15
1973	8	0	0	0	0	1	2	11

Table 3
Tuberculosis Incidence Rates and Figures for Newark —
1972-1973-1974

	1972	1973	1974
New Active Cases	257	226	169
Rate per 100,000			
Estimated Population	67.2	59.1	44.2

It is probable that the figures of Smith, *et al.* reflect something other than actual incidence figures. Under the recent guidelines adopted by the State of New Jersey and the National Center for Disease Control⁵ a number of the patients counted by these authors probably should have been discharged from medical care and not counted as "suffering from the same disease." Setting this aside, the question is, does the use of BCG have anything to offer any of them? How many of these cases are children who would be eligible to receive BCG? Our current state of knowledge leads us to believe that 92 percent of the persons with Stage III tuberculosis were infected in the past and reactivated due to unknown causes. The overwhelming majority of these are adults. It is generally accepted that BCG is not indicated in this group, which does not have new infection.

Smith, *et al.* cite reports of failure to get patients to take Isoniazid[®] preventive therapy. It has been our experience that dedicated, imaginative programs, run by health professionals who believe in what they are doing, does obviate this problem. We are in the process of demonstrating this at the Martland Hospital Comprehensive Pulmonary Disease Clinic which was recently set up on the recommendation of the Newark Comprehensive Health Plan.⁶

Is there a place for BCG in Newark? The new specific recommendations of the Advisory Committee on Immunization Practices¹ state that:

1. BCG vaccination should be seriously considered for persons who are tuberculin skin-test negative and who have repeated exposure to persistently untreated or ineffectively treated, sputum-positive pulmonary tuberculosis.

2. BCG vaccination should be considered for well-defined communities or groups if *an excessive rate of new infections can be demonstrated* (italics are the author's) and the usual surveillance and treatment programs have failed or have been shown not to be applicable. Such groups might exist among the socially disaffiliated and those without a regular source of health care, possibly including some alcoholics, drug addicts, and migrants. Groups such as health workers, who may be at particular risk of exposure to unrecognized pulmonary tuberculosis should, where possible, be kept under surveillance for evidence of newly acquired tuberculous infection. *It must be recognized that only the occurrence of new infections reflects whether transmission is actually occurring.* (italics are the author's)

As far as is known, the overwhelming majority of cases of tuberculosis in Newark do not fall under either of these two categories. Therefore, except in individual circumstances that are well defined (such as the newborn of an untreated, unwilling-to-be-treated mother, who is at increased risk of contracting miliary or central nervous system tuberculosis) there is no place for use of BCG in Newark.

References

1. Recommendations of the Public Health Service Advisory Committee on Immunization Practices — BCG vaccines. *CDC Morbidity and Mortality Report* 24:69-70, 1975.
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3. Waaler H and Rouillon A: BCG vaccination policies according to the epidemiological situation. *Bull Int U Tuber* 49:166-189, 1974.
4. American Thoracic Society: Diagnostic standards and classification of tuberculosis and other mycobacterial diseases. New York, American Lung Association, 1974.
5. Center for Disease Control Tuberculosis Advisory Committee: Recommendations for health department supervision of tuberculosis patients. *Morbidity and Mortality Weekly Report* 23:56, 1974.
6. Newark Comprehensive Health Plan — 1975-1976. Newark Health Planning Agency, Department of Health and Welfare, p. 47.

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Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

October 19, 1975

A regular meeting of the Board of Trustees was held on October 19, 1975, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Policy Statement on Support of Litigation . . . Approved the following recommendation of the Executive Committee concerning the Society's policy on support of litigation instituted by specialty societies:

The Medical Society of New Jersey will not, without prior authorization by the Board of Trustees or the Executive Committee, become a party plaintiff to any litigation nor sustain a financial commitment in support thereof. Each and every situation must, of necessity, be evaluated on an *ad hoc* basis.

Relationship of Insurance Broker and Committee on Medical Defense and Insurance to Board of Trustees . . . Approved the following recommendation from the Committee on Medical Defense and Insurance:

That the Committee on Medical Defense and Insurance be empowered to employ expert analysts for specific tasks at hand regarding all of the Society's insurance programs and that the initial budget be established at \$25,000.

Professional Liability Program . . . Approved the following recommendation from the Committee on Medical Defense and Insurance:

That the entire membership of the Society receive a mailing clarifying the final rate increase for professional liability insurance, taking into consideration risk factors, administrative costs, and so on, and comparing the final increase with what MSNJ originally recommended.

Loss Control Program Cases Referred to Specialty Societies . . . Approved the following recommendations #1 and #2 from the Committee on Medical Defense and Insurance and added recommendation #3 which was also approved.

1. That when the county medical review and advisory committee determines a case is nondefensible and the physician involved wishes to contest the case, the appropriate specialty society will be so notified.

2. That when the county medical review and advisory committee determines a case is defensible and the physician involved refuses to defend the case and wishes to settle, the appropriate specialty society will be so notified.

3. That the ultimate decision is that of the medical review and advisory committee and should the specialty society believe the individual physician is correct, the case will be resubmitted with appropriate additional documentation to the medical review and advisory committee.

Constitution . . . Approved the following recommendations from the Committee on Long Range Planning and Development:

That the Board of Trustees approve the following (MSNJ) Constitution for submission to the Standing Committee on Revision of Constitution and Bylaws.

Note:

In the discussion which resulted in the above recommendation, the Committee on Long Range Planning and Development considered the following items from the minutes of that Committee's meeting of October 8, 1975:

(a) The current Constitution is not concise and flexible; it is cumbersome, restrictive, and resistant to change.

(b) Consideration was given to lengthening terms of officers to two years, or allowing an officer to continue until voted out of office.

(c) Consideration was given to changing day of election session to a later time in the convention schedule to allow delegates to interview candidates prior to the election.

(d) Suggestion was made for a town meeting forum during the convention when potential candidates could make their views known on issues affecting the Society.

(e) Suggestion made that Nominating Committee not consider any candidate who does not announce his candidacy or fails to supply a copy of his curriculum vitae in time for printing and distribution to the delegates prior to election.

(f) No mechanism presently exists whereby the Society can collect dues for a special assessment other than at the time of the annual meeting.

(g) There is a need for clear delineation of the roles and responsibilities of the President and the Chairman of the Board of Trustees.

Constitution

Article I — Title

The name of this organization is the "Medical Society of New Jersey."

Article II — Purposes

The purposes of this Society are to promote the betterment of the public health and the science and art of medicine, to

enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of the practitioners of medicine.

Article III — Component Societies

County medical societies that hold charters from this Society shall be known and referred to as component societies. There shall be no more than one component society in any county of this State.

Article IV — Members

This Society is composed of individual members of component societies and others as provided in the Bylaws.

Article V — House of Delegates

The House of Delegates shall be the legislative and policy-making body of this Society and shall consist of Fellows, Officers, and Delegates as prescribed in the Bylaws.

Article VI — General Officers

The general officers of this Society shall be the elected officers and elected trustees as defined in the Bylaws. Their terms of office and qualifications shall be provided in the Bylaws.

Article VII — Trustees

The Board of Trustees is composed of those elected officers so designated in the Bylaws and the elected trustees, and shall constitute the executive body of the Society at such times as the House of Delegates is not in session. Its duties are those prescribed by law governing trustees of corporations and as may be prescribed in the Bylaws.

Article VIII — Sections

The House of Delegates or the Board of Trustees may provide for the division of the scientific work of this Society into sections whenever the necessity therefor arises.

Article IX — Meetings

The House of Delegates and the Scientific Sections shall meet at least annually and at such other times as are deemed necessary by the House or the Board of Trustees as provided in the Bylaws.

Article X — Funds, Dues, and Assessments

Funds shall be raised by dues and assessments on the membership as approved by the House of Delegates as provided in the Bylaws.

Article XI — Councils and Committees

Councils and Committees shall be established by the House of Delegates or the Board of Trustees as provided in the Bylaws.

Article XII — Amendments

The House of Delegates may amend this Constitution at any meeting providing that the proposed amendment shall have been circulated to the House and the component societies in writing at least 30 days prior to said meeting and a report by the Committee on Constitution and Bylaws is available to the House. A two-thirds majority of those present and voting shall be necessary for adoption.

Audit Review . . . Approved the following recommendations from the Special Committee on Audit Review:

1. That the dues year and fiscal accounting year remain unchanged and that this recommendation be referred to the Committee on Revision of Constitution and Bylaws and the Committee on Finance and Budget.

Note: The Financial Manager detailed the current dues-collection procedure and explained the financial advantages to be lost by unification of the dues and fiscal years; the Executive Director related the administrative problems under the current system; the Committee was of the opinion that there are greater financial advantages in *not* aligning the two years.

This action rescinds the Board's previous decision to unify the two years (9/21/75)

2. That the Committee on Annual Meeting be requested to review annually the format on underwriting the expenses of the Inaugural Reception.

Note: On 7/20/75 the Board directed that, in the future, MSNJ will underwrite the entire expense of the Inaugural Reception and that control of this expense will be the responsibility of the Annual Meeting Committee.

. . . Noted that the balance of the General Fund is in keeping with the policy adopted 10/20/74 that on the basis of current monthly operating costs a minimum of four and preferably six-months reserve be maintained.

. . . Noted that the net deficit for Journal publication last year was \$39,350.84; effective June 1, 1975, MSNJ engaged United Media Associates as its national advertising sales representative, replacing the State Medical Journal Advertising Bureau; it is expected that national advertising revenue will increase by 15 percent.

. . . Noted that the net deficit for the 1975 annual meeting was \$17,565.13.

. . . Noted that this year's interest yield on investment was higher by \$7,927.23, for a total of \$41,217.83; Medical Student Loan Fund net investment income was \$684 greater than the previous year.

. . . Noted that a copy of the Audit Report and the minutes of the Audit Committee's meeting are being forwarded to each component society.

. . . Requested that copies of the Audit Report and Audit Committee minutes be sent to the members of the Board of Trustees.

JEMPAC Survey of Assembly Candidates . . .

Received as informative the results of the survey of Assembly candidates on the subject of professional liability and directed that they be disseminated to county society and specialty society offices urging that the information be transmitted to their membership and that individuals personally contact legislators.

. . . Urged the members of the Board of Trustees to visit the counties comprising their districts to answer questions on the survey results.

. . . Directed that JEMPAC be requested, as an educational activity, to survey candidates on important issues before every state and national election.

National Health Planning and Resources Development Act of 1974 (PL 93-641) . . .

Directed that the following be adopted as the official position of MSNJ in relation to PL 93-641 as it applies to New Jersey:

(1) That the formation of Health Systems Agencies be democratically generated from the community in line with the following points:

(a) That county councils, which are broadly representative of the population, be established in each county with professional providers designated by the various health-care professional organizations operating in the county, including, but not limited to, medical, osteopathic, optometric, podiatric, nursing, physical therapy, speech therapy, and hospital administrators.

(b) That these county health care councils elect representatives to a central agency to be known as the Health Systems Agency of the area in which the counties are located, and these elected representatives constitute the Agency's Board of Directors, such elections to be made on an equitable basis, considering the geographical and population characteristics of the area served.

(c) That consumer members of the county councils represent county-wide civic, patriotic, business, religious, and other societies or associations, so that each consumer member does, in fact, represent an identifiable group within the county and is not merely a selectee of a central self-perpetuating group of persons, however well motivated they may seem at present.

(d) That the county councils prescribe the manner or method of admitting to its membership individual citizens who are not representatives of county-wide groups.

2. That competing agencies not decide which agency shall ultimately be selected.

3. That the practicing physicians' opinions and input shall be maximum in the formative stages.

4. That the decision as to formation of the HSA shall be based upon community acceptance rather than decisions of agencies with a vested interest.

Woman's Auxiliary Annual Meeting . . .

Authorized the transfer of the Woman's Auxiliary portion of the 210th Annual Meeting to the Rickshaw Inn or other nearby facility, since the Cherry Hill Hyatt House is not large enough to accommodate all of the Auxiliary's activities.

Annual Meeting — 1977 . . . Agreed to the recommendation of the Committee on Annual Meeting to notify the Cherry Hill Hyatt House to hold the dates of June 4 to 7, 1977, for the 211th MSNJ Annual Meeting.

Exchange with AMA Delegates and County Representatives . . .

Received a suggestion from Dr. Franzoni, AMA Alternate Delegate, that the Chairman of the New Jersey AMA Delegation, or his designee, meet with the Conference of Presidents and Presidents-Elect to effect a meaningful exchange of opinion. (This suggestion was agreed to by the Conference as a desirable one.)

Professional Training Institute — Legislation and Public Relations . . .

Authorized the Executive Director to hold (at the Executive Offices) a series of seminars for members of the Executive Committee and the Councils on Legislation and Public Relations; the cost to the Society will not exceed \$1200.

Conference of Presidents and Presidents-Elect . . .

Received the following report from the morning's 22nd Conference of Presidents and Presidents-Elect of Component Societies:

1. *Minutes of Previous Conferences* — Request was made that the representatives to the Conference be supplied with the minutes of the previous meetings of the Conference of Presidents, to aid in their deliberations.

2. *Professional Liability* — All representatives were not in agreement with MSNJ's proposed program on professional liability; it was their opinion that a more consolidated approach should be taken.

MSNJ has been advised that the best approach to legislative enactment is with a multi-bill package, thus eliminating the possibility of an omnibus bill being defeated because of objection to a given section.

The House of Delegates, with the passage of the resolution on professional liability, had mandated action; the timing was bad for passage of such bills; the resolution called for

"an organized, integrated program" (which did not exist at the close of the Annual Meeting); there was no further directive. Bills drafted by other component societies were discussed and an attempt was made to explain why the Board felt the Society's bills were more acceptable. The Ad Hoc Committee on Professional Liability will prepare, for presentation to the meeting of the House of Delegates in December, a package on ways in which the entire professional liability problem can be handled at MSNJ and at the county level.

3. *Better Attendance at Local Meetings* — Suggestion was made that MSNJ obtain recommendations from component societies on ways in which attendance at county meetings can be increased, which can be disseminated to all county societies.

4. *Second Opinion Consultation with Blue Shield* — Suggested that MSNJ staff investigate the second opinion consultation problem with New Jersey Blue Shield.

5. *Medicaid Regulations* — The Executive Director reviewed the following actions taken by the Board of Trustees on 9/21/75 concerning Medicaid fee reduction:

On August 20, 1975, The Medical Society of New Jersey registered a vigorous protest at a public hearing on the fee reductions and the generic drug provisions. The State has postponed the effective date of the generic regulations.

In regard to the fee reductions MSNJ lodged a complaint with the Office of the Public Advocate on August 6, 1975. MSNJ has been advised that although the Department of Institutions and Agencies and the Office of Administrative Procedure have verbally assured procedural integrity, the Public Advocate is pursuing "substantiation of compliance." The following recommendations were submitted to the Board in the order of chronological precedence and preference:

(a) That notification be sent to the Department of Institutions and Agencies, the Governor, and the Department of Health, Education, and Welfare indicating that MSNJ withdraws its support of the Medicaid Program as it is administered in New Jersey.

(b) That notification of the above be sent to all members of MSNJ, with the added proviso that the question of whether or not to render services under the Medicaid Program in non-emergency situations is a purely personal decision of the physician.

The Board directed that all communications to members of this Society pertaining to recommendation #2, include caution of possible charges of abandonment and specific instructions on how this might be avoided.

(c) That MSNJ proceed with an audit of Medicaid books utilizing Society personnel assigned by the Executive Director.

(d) That MSNJ continue to pursue the complaint through the Public Advocate.

(e) That MSNJ seek remedial legislation to include amendments of Medicaid reimbursement under the Cost of Living Index.

(f) That if all of the above fails, litigation as to all issues with a reasonable chance for success be initiated.

At this same meeting the Board of Trustees appointed an *ad hoc* committee to develop a report for submission to the special session of the House on the Medicaid situation.

6. *Indoctrination of Chairmen of Judicial Committees* — Request was made that MSNJ consider changing the indoctrination meeting date for county judicial committee chairmen which is usually held in January. It was suggested that the meeting be held at the end of the fiscal year or the first week of the new fiscal year (i.e., May or June).

7. *Medical Education Credits* — Attention was called to the fact that some of the county medical societies are experiencing difficulties in obtaining category I credits for scientific programs held at county medical society meetings.

The conferees were informed that this problem will be taken under advisement by the Committee on Medical Education.

8. *Communications* — Conferees expressed concern over the tremendous amount of information being sent out to county offices. The problem seems to be that the physicians do not have the time to read the materials sent to them.

Suggestion was made that a bulletin be sent to county officers following each Board meeting containing only the most important or problem issues.

The suggestion was also made that Trustees be invited to attend meetings of the county societies comprising their judicial districts. It was noted, however, that it is the responsibility of the county medical societies to notify the Trustees of the dates and times of these meetings.

9. *List of Physicians with Credentials* — Conferees were informed that a list of physicians licensed in New Jersey (with credentials) could be obtained from the State Board of Medical Examiners, 28 West State Street, Trenton, New Jersey 08625.

10. *P.L. 93-641 — National Health Planning and Resources Development Act of 1974* — Definitive action was taken on this subject. (See official position of MSNJ on PL 93-641 on page 1053 of these minutes).

The following items were brought to the conferees' attention by the Board:

1. *Special Committee to Investigate and Study Medical Malpractice Insurance* — On Friday, October 24, 1975, a meeting of the Senate Special Committee to Investigate and Study Medical Malpractice Insurance will be held. James S. Todd, M.D., Chairman of the Board of Trustees and of the Ad Hoc Committee on Professional Liability, will present the Society's position. Anyone wishing to attend this meeting can meet with MSNJ representatives at 9 a.m., at the Executive Offices on the morning of the meeting.

2. *AMA Delegates* — As previously mentioned in these minutes (see page 1053) suggestion was made that time be allotted during the meeting of the Conference of Presidents and Presidents-Elect for the Chairman of the New Jersey Delegation to the AMA or his designee to meet with county officers.

3. *JEMPAC* — Henry J. Mineur, M.D., Chairman of JEMPAC, presented a brief statement on the recent survey results of Assembly candidates. Dr. Mineur further emphasized the importance of becoming a member of JEMPAC.

Anyone desiring an application for membership should write to the Executive Offices, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

4. *Physician Registration* — Dr. McGuire informed the conference group that the State registration forms for New

Jersey physicians have been mailed. If any physicians previously failed to complete the registration form, he suggested that they contact the State Board of Medical Examiners, 28 W. State Street, Trenton, New Jersey 08625. There is a late registration penalty fee of \$20 for those who previously failed to register.

The Federal Privacy Act

(The following message to New Jersey physicians was prepared by the Division of Disability Determinations of the Department of Labor and Industry.)

Disclosure of Medical Reports in Social Security Disability Claims

The privacy Act of 1974 (PL 93-579), passed by Congress in December 1974, and signed by the President on January 1, 1975, became effective on September 27, 1975. The basic purpose of the Privacy Act is to safeguard an individual's privacy by regulating the collection, maintenance, use, and dissemination of personal information by federal agencies on that individual. Among other provisions, the new law gives individuals the right to inspect records about themselves (including medical records) that are maintained by federal agencies.

Briefly, the Privacy Act requires federal agencies to: (1) collect, maintain, use, or disseminate records of identifiable personal information in a manner that assures that such action is for a necessary and lawful purpose, that the information is current and accurate for its intended use, and that adequate safeguards are provided to prevent misuse of information; (2) permit individuals to determine what records pertaining to them the agency collects, maintains, uses, or disseminates; (3) permit individuals to prevent records pertaining to them obtained for a particular purpose from being used or made available for another purpose without their consent; and (4) permit individuals to gain access to information pertaining to them in federal agency records and to have a copy made of their records (including medical records).

Disclosure of Medical Records by the Social Security Administration

The number of requests from individuals to inspect medical reports obtained in connection with their disability claims is expected to be

relatively small. In the majority of requests received, the individual will already be generally aware of the information in the medical reports. There will be a small percentage of cases in which direct access to a medical report may have an adverse effect on the individual. Procedures, therefore, call for a screening of medical reports to identify these cases. In such cases the report will be released only to an authorized representative designated by the individual. The procedures apply to both Social Security and Supplemental Security Income Disability Claims.

Complete and Objective Medical Reports Still the Goal

The new information disclosure provisions do not change the way physicians should complete medical reports in connection with a patient's disability claim. As always, the emphasis is on the type of objective reporting — symptoms, signs, and laboratory findings relating to the patient's condition — that is required for impartial disability determinations under both programs.

Further information about the disclosure of Social Security medical records is available from any Social Security office or the Division of Disability Determinations, P.O. Box 649, Newark 07101.

Payment for Evidence of Record

If your patient has applied for supplemental Security Income Benefits, the Division of Disability Determinations is able to pay for evidence of record. However, the Division is not permitted to pay for evidence of record for patients who have applied for Social Security Disability Benefits. The applicant is responsible for any charge for this service.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center of the New Jersey Regional Medical Program and the Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, conjointly compile the information contained in this column each month. The New Jersey component is located at the Valley Hospital in Ridgewood. The Center serves as a source of intelligence on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Project Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College is pharmacologist consultant. The service is free, available Monday through Friday from 9 a.m. to 5 p.m.—telephone (201) 445-4900, extension 132. Following are questions and answers handled by the Center recently.

1. Please provide me with information concerning the skin tests for penicillin allergy.

Allergic reactions to penicillin can be divided into immediate, accelerated, and late reactions. Immediate reactions generally occur within 20 minutes, usually with such symptoms as urticaria, flushing, and diffuse pruritus. Less commonly, the reactions are anaphylactic and may include shock, cardiac arrhythmias, and laryngeal edema. Accelerated reactions start between one and 72 hours after penicillin therapy, usually as urticaria, but angioneurotic and laryngeal edema may also be seen. Late reactions begin days to weeks after therapy starts, usually with urticaria or other rashes, fever, blood dyscrasias, and Coombs-positive hemolysis may also occur.^{1,2}

Two types of skin-test materials are now being used to predict hypersensitivity reactions to the penicillins: (1) major determinant, which is available as benzylpenicilloyl-polylysine (Pre-Pen, Kremers-Urban) also called BPL and

(2) minor determinants (MDM), which include penicillin G and its hydrolysis products.¹

Patients who have a positive skin test with BPL are likely to have an allergic reaction to a therapeutic dose of penicillin. However, a negative reaction to BPL alone does not exclude the possibility of an anaphylactic reaction.³ Therefore, tests that utilize MDM in conjunction with BPL are better indicators of a potential reaction to penicillin.¹

Levine and Zolov reported the results of a long-term prospective evaluation of skin testing to predict penicillin allergy in patients with a past history of penicillin allergy. They utilized the two penicillin antigen groups, BPL and MDM, concurrently and found that only one of 185 patients with histories suggesting penicillin allergy, who had negative reactions to both BPL and MDM, developed an accelerated reaction during treatment with penicillin. None of the patients had an immediate reaction. This compared to eight of 11 patients with positive skin tests who subsequently had immediate or accelerated reactions when treated with penicillin. Thus, these skin tests were found to be valuable predictive tests for immediate and accelerated allergic reactions to penicillin.

Although BPL is commercially available, MDM is not. However, aqueous penicillin G itself can be used as a substitute for MDM. Most patients who have positive skin tests with the MDM also have positive skin tests with aqueous penicillin G. Since an intradermal injection of penicillin G can cause a severe reaction, the first skin test should be performed by scratch using a 5-unit per ml solution of aqueous penicillin. If there is no local reaction after about 20 minutes, a scratch test using 10,000 units per ml should be performed. If there is no local reaction after about 20 minutes, an intradermal injection of a solution containing 10,000 units per ml is done with just enough of the solution to raise a tiny blister. Saline is used for a control scratch and intradermal injection.^{1,2,5}

In conclusion, BPL when used alone can predict some allergic reactions to penicillin, but may fail to predict anaphylactic hypersensitivity reactions. Skin tests with both BPL and MDM, or its substitute penicillin G, can more reliably identify the patient who is likely to have an allergic reaction to penicillin.

References

- ¹Anon: Tests for penicillin allergy. *Med Let* 17:54, 1975.
 - ²Anon: *Handbook of Antimicrobial Therapy* (revised). New Rochelle, New York, The Medical Letter, Inc., p. 40.
 - ³Anon: Pre-Pen® skin test antigen — K-U. *Pharm Index* (Mar.) 1975, p. 4.
 - ⁴Levine B B and Zolov D M: Prediction of penicillin allergy by immunological tests. *J Allergy* 43:231-244, 1969.
 - ⁵Anon: Testing for penicillin allergy with aqueous penicillin G. *Med Let* 17:84, 1975.
2. Are there any reports of nephrotoxicity being associated with Keflin administration?

Since its introduction, the cephalosporin derivative, cephalothin sodium (Keflin,® Eli Lilly), has been used successfully in the treatment of a variety of gram-positive and gram-negative bacterial infections. Cephalothin was generally believed to be devoid of nephrotoxicity in spite of

the well recognized nephrotoxicity of another cephalosporin derivative, cephaloridine. However, several recent reports have suggested that cephalothin may indeed exhibit nephrotoxic effects.

Burton, *et al.*¹ reported five cases of acute renal failure associated with the administration of cephalothin 4 to 16 gm. daily. In each of the five patients reported, renal function deteriorated three to ten days after cephalothin therapy was begun and spontaneously improved within one to eleven days after its withdrawal. The clinical features in all patients included microscopically apparent hematuria and pyuria and transient increases in BUN and serum creatinine levels. One patient developed oliguria, two developed rashes, and two developed eosinophilia; but none had fever correlated with cephalothin therapy. Although three patients had received other nephrotoxic antibiotics, the close temporal relationship strongly suggested that cephalothin therapy was the actual cause of the transient loss of renal function.

Engle and co-workers² described the development of renal failure severe enough to require hemodialysis in a male patient who received cephalothin 16 gm. per day for eight days.

Carling and co-workers³ described three patients who while receiving 8 to 12 gm. per day of cephalothin developed acute renal failure which appeared to reflect a direct nephrotoxic effect of cephalothin. The course and findings were consistent with acute tubular necrosis of the oliguric and non-oliguric types. All patients recovered after discontinuation of cephalothin therapy, although peritoneal dialysis was required in one.

In another report, acute renal failure developed in six patients following treatment with cephalothin 6 to 24 gm. daily. Autopsy performed on four patients who had died due to their acute disease state revealed severe tubular damage. Although all had received other potentially nephrotoxic antibiotics, the close temporal relationship between cephalothin therapy and anuria suggested a possible causal relationship between this antibiotic and acute renal failure.⁴

Studies have also noted the aggravation of pre-existing renal disease by cephalothin therapy^{5, 6} and the possible increased nephrotoxic effect when cephalothin is combined with gentamicin.⁷⁻¹⁰

In conclusion, cephalothin appears to be potentially nephrotoxic. Administration of high doses to patients with pre-existing renal disease, or concomitant administration with other nephrotoxic drugs should be avoided.

References

¹Burton J R *et al*: Acute renal failure during cephalothin therapy. *JAMA* 229:679-682, 1974.

²Engle J E, *et al*: Reversible acute renal failure after cephalothin (Letter to the Editor). *Ann Intern Med* 83:232-233, 1975.

³Carling P C, *et al*: Nephrotoxicity associated with cephalothin administration. *Arch Intern Med* 135:797-801, 1975.

⁴Anon: Sodium cephalothin — acute renal failure. *Clin Alert* 182, (Oct 12) 1973.

⁵Pasterant D P and Stephens B G: Reversible nephrotoxicity

associated with cephalothin therapy. *Arch Intern Med* 135:599-602, 1975.

⁶Pickering M J, *et al*: Declining renal function associated with administration of cephalothin. *South Med J* 63:426-428, 1970.

⁷Cabanillas F, *et al*: Nephrotoxicity of combined cephalothin — gentamicin regimen. *Arch Intern Med* 135:850-852, 1975.

⁸Kleinknecht D, *et al*: Acute renal failure after high doses of gentamicin and cephalothin. *Lancet* 1:1129, 1973.

⁹Fillastic J R, *et al*: Acute renal failure associated with combined gentamicin and cephalothin therapy. *Br Med J* 2:396-397, 1973.

¹⁰Bolrow S N, *et al*: Anuria and acute tubular necrosis associated with gentamicin and cephalothin. *JAMA* 222:1546-1547, 1972.

3. Are there any reports in the literature of aplastic anemia following administration of chloramphenicol exclusively by parenteral routes?

This question is being asked of our Drug Information Center with increasing frequency. Several articles have appeared in the literature which link the fatal aplastic anemia, associated with chloramphenicol, to the oral dosage form of the drug.^{1, 2} (The aplastic picture is not to be confused with the milder form of chloramphenicol-induced bone marrow toxicity that is dose related, shows a normocellular marrow, and is reversible.³)

Experience with chloramphenicol reveals an incidence of aplastic anemia of approximately one in 40,000 or more courses of therapy.⁴ This disorder may not follow the use of chloramphenicol by parenteral routes. One theory that may explain the difference in toxicity between dosage forms has been proposed by Holt.⁷ He suggests that when chloramphenicol is taken orally, some component of the intestinal flora may degrade it causing the formation and absorption of metabolic products that depress the bone marrow. Whether this is the mechanism by which the aplastic anemia occurs remains obscure.

Information made available to us by the manufacturer⁶ (unpublished data on file at Parke-Davis Company, Detroit) suggests that aplastic anemia may not follow the use of chloramphenicol by parenteral routes. One theory that may explain the difference in toxicity between dosage forms has been proposed by Holt.⁷ He suggests that when chloramphenicol is taken orally, some component of the intestinal flora may degrade it causing the formation and absorption of metabolic products that depress the bone marrow. Whether this is the mechanism by which the aplastic anemia occurs remains obscure.

The manufacturer's investigation into aplasia from chloramphenicol revealed only five recorded cases where aplastic anemia was purported to occur following parenteral doses alone. However, after further investigation they found that one patient did receive an oral dose of the drug, two cases received other drugs known to produce aplastic anemia, one case was associated with a viral infection, and the final case occurred in an elderly patient who was in an age group where idiopathic aplastic anemia is known to occur.

In conclusion, our review cannot rule out the possibility that chloramphenicol, administered by parenteral route, is not associated with aplasia. The caution that appears in the official package literature concerning possible aplastic reactions should be heeded until this question is resolved.

References

¹Gleckman R A: Warning — chloramphenicol may be good for your health. *Arch Intern Med* 135:1125, 1975.

²Holt R: The bacterial degradation of chloramphenicol. *Lancet* 2:1259-1260, 1967.

³Kagan B M: *Antimicrobial Therapy*, 2nd ed. Philadelphia, Saunders, 1975, pp 424-425.

⁴Gilman A and Goodman L S: *The Pharmacological Basis of Therapeutics*, 5th ed. New York, Macmillan, 1975, p 1196.

⁵Pisciotta A V: Idiosyncratic hematologic reactions to drugs. *Postgrad Med* 55:106-107, 1974.

⁶Personal communication from Parke-Davis Company, Detroit, Michigan.

⁷Anon: *Physicians' Desk Reference*, 29th Ed. Oradell, New Jersey, Medical Economics Company, 1975, pp 1118-1120.

Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

The following is a statement of the Board of Trustees of the New Jersey Foundation for Health Care Evaluation. It expresses their concern about the decision of HEW to discontinue funding statewide Support Centers after June of 1976. (One of the functions of NJFHCE has been to act as the Support Center for the eight PSROs of New Jersey).

NJFHCE has functioned as the Support Center for New Jersey since the very beginning of the PSRO program. We were charged with helping the eight local physician organizations to qualify as PSROs. A partial list of the tasks involved includes the following:

1. The Board of Trustees of NJFHCE was established as a forum for all the PSRO areas (all have Board members). It began its work prior to any funding by HEW. Board members are *not* compensated for their time and work.

2. Each area was provided with organizational help, such as establishing model constitution and by-laws, legal counsel to advise on the corporate laws of New Jersey, development of internal audit systems, assistance in recruiting Executive Directors and Nurse Coordinators, and technical assistance to management and secretarial staffs.

3. Publication of criteria for 134 diagnoses, with the assistance of the specialty societies of New Jersey ("Book of Norms").

4. Investigation of the coordination of data and information, via a Committee on In-House Review, and a consortium including representatives of third party carriers, intermediaries, and the New Jersey Hospital Association. A data plan has been developed.

5. Wide dissemination of PSRO and related information by means of prepared slide programs, newsletters, speakers'

bureau, and frequent articles in MSNJ's and other publications. Exhibits and PSRO sessions at annual MSNJ meetings, and seminars held on a statewide basis are also part of this process. Board members and staff have participated in frequent programs and on-site discussions with hospital personnel and medical staffs.

6. We maintain continuing liaison with Federal agencies, including Medicare, Medicaid, and Maternal and Child Health, as well as the appropriate State agencies for each. Memoranda of Understanding with these agencies and the hospitals have been pursued by the PSROs with the assistance and coordination of NJFHCE.

7. NJFHCE's Utilization Review Coordinator acts as liaison to hospitals, PSRO areas, and coordinator organizations. She has been active in training seminars, and is preparing a handbook for the coordinators.

8. Continuing managerial assistance to the PSROs. The preparation of documents and reports of all types required by governmental agencies is done by the PSROs with NJFHCE assistance.

9. Investigation, with the PSROs, of the participation of non-Federal patients under the PSRO-type review programs.

10. Focus of information in a wide variety of non-governmental enterprises, including commercial abstract systems, national specialty societies, activities in other states, data collecting and processing systems, non-physician practitioner groups, and so on.

In each of these activities, and many more, the PSROs have pursued their goals in their own best interests, with the coordination of the Foundation. Local autonomy has been preserved at all levels. The Support Center does not attempt to dictate any decisions to the capable personnel and officers of our PSROs. The Foundation, in turn, has likewise developed many approaches and programs in accordance with the needs of New Jersey physicians.

We have voiced our concerns about the forces which have delayed the implementation of the PSRO program. Thanks to the industry and patience of all involved — the response of New Jersey physicians has been remarkable — we now have five funded areas in our State. One, Passaic Valley, is in Conditional status and is actually operating. We feel strongly that several others should be in the Conditional category at this point.

It is clear that HEW does not intend to fund Support Centers after June of 1976. This concerns us greatly, and produces a feeling of frustration. While the 13 Support Centers

nationwide have not been uniformly effective, there is a consensus, in and out of our State, that NJFHCE has been one of the more successful. This is due in large part because of the cooperation with the local PSROs, and the fact that no deliberations or decisions have been made without their participation and concurrence.

Despite our effectiveness, or perhaps because of it, we are told that we can only survive as a Support Center by subcontracting with the PSROs to provide services for them. The budget has restricted the number of Conditional PSROs, and also reduced the available dollars for each. While HEW seems to think that there will be little need for coordination by next summer, or that the Region II office in New York City will be able to fill the needs of New Jersey, we feel that there will be an enormous amount of work to be done in this State for some time to come. As additional PSROs become Conditional, as larger areas come under their surveillance, as increasing numbers of physicians, hospitals, and patients begin to be affected by the review system, the need for a coordinating agency with a statewide perspective will increase. Also, as a statewide Professional Standards Review Council comes into being (after three PSROs are in Conditional status), it should be able to benefit from the experience of the organization that has been in the program from the beginning. We trust, in this regard, that MSNJ will look to the Board members of NJFHCE in selecting its nominees to the statewide Council.

Many people, in and out of government, were overwhelmed by the response of physicians to the challenge of Senator Bennett and Public Law 92-603. No group responded more effectively than those farsighted individuals who established this Foundation. The need for NJFHCE is only beginning. We hope to be permitted to continue to function as a Support Center. If not, we will continue our work as *your* New Jersey Foundation. We will still be looking at the Health Planning and Resources Development Act (P.L. 93-641), HMO and IPA trends, third party relationships, and whatever else lies over the horizon. As always, we will continue to operate from the viewpoint of the practicing physicians of New Jersey, determined to maintain quality as the most significant factor in the delivery of medical care.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

The College of Medicine and Dentistry of New Jersey's long-sought program of medical education for South Jersey moved closer to reality in October, when it was endorsed by the State's Board of Higher Education.

Although the State Legislature, with Governor Byrne's approval, set September (1976) for the initiation of the program for allopathic and osteopathic students, the legislation did not provide funds. CMDNJ has asked for \$700,000 for the South Jersey Medical Education Program for fiscal year 1976-77. There appears to be enough professional, political, and community interest so that we can now regard the program as a very real possibility.

The South Jersey program has been sought by the local community since the 1960's. Official impetus for the program came in late 1971, when then Governor Cahill directed CMDNJ to prepare a feasibility study on its need. With completion of the study in 1973, the Governor directed that planning proceed.

A South Jersey Medical Education office was established in Camden early in 1975, and is actively supported by an advisory council of area professional, business, and civic-group leaders. An academic adviser, the eminent Dr. William A. Sodeman, former Dean of Jefferson Medical College and former Chairman of the AMA's Council on Medical Education, has played a key role in advancing the educational aspects of the program. With Dr. Sodeman's assistance, the South Jersey planner, Ms. Agnes McGinnis, has established residency coordinating committees for both the allopathic and osteopathic hospitals in the area. (Each hospital is represented by its chief of staff or director of medical education.) One result of this effort has been the collection of background information on the strengths of the hospitals' facilities, depths of staff, teaching experience, approved residency programs, and interest in participating in the program.

What kind of program will it be? Essentially — partly because of the advice of the Liaison Committee on Medical Education — it is being

developed as a clinical satellite to one or both of our existing medical schools, CMDNJ-Rutgers Medical School, Piscataway, and CMDNJ-New Jersey Medical School, Newark. Thus students in the South Jersey program will take their basic science work at the northern schools and move to participating hospitals in South Jersey for their third and fourth year clerkships.

As now planned, Camden's Cooper Medical Center, which is being remodeled and enlarged, will serve as the core hospital. However, other hospitals throughout the area, including a number of osteopathic hospitals, have shown great interest in becoming part of the clinical teaching structure.

CMDNJ's South Jersey Medical Education Program appears to some to have become inextricably bound into the effort to obtain a new Veteran's Administration Hospital for the Camden area. The administration of the College, higher education agencies of the State, and many other New Jerseyans are on record in support of the proposed hospital. Local newspapers reported that the Board of Higher Education's recent approval of the program had cleared away "the last substantive obstacle" in the path of the VA facility. CMDNJ hopes this is true. However, we reiterate that South Jersey needs our program and that our implementation plans will go ahead whether or not the VA Hospital is built.

To the people of the southern part of the state, our program holds the promise that they will begin to be provided with physicians trained in New Jersey. It has been reported that the region has the smallest percentage of physicians-to-population of any in the state. If experience has validity, students in the South Jersey program probably will be disposed toward settling in South Jersey, especially if the hospitals there are able to build and offer the post-graduate programs that they are capable of sponsoring.

The area has had considerable experience in medical education because of its proximity to Philadelphia. Our study showed, for example, that in the seven-county region, 14 members of hospital staffs hold the rank of professor in a medical school; 34, associate professors; 41,

assistant professors; 7, clinical professors; 26, clinical associate professors, and 65, clinical assistant professors. They total 187; 125 of whom are in three Camden-area hospitals. In addition, there are 207 members of hospital staffs holding faculty ranks ranging from preceptor to senior instructor. There are 152 in this group in Camden and 55 elsewhere in the region.

As currently planned, the CMDNJ-South Jersey Medical Education Program will be under the jurisdiction of a deputy dean who, with his staff, will be located in Camden. A core full-time clinical faculty will be appointed in South Jersey reporting administratively to the deputy dean, but academically to the department chairmen of the parent schools.

The thrust of our South Jersey program will be toward primary care, but obviously it will cover study and experience in all aspects of the medical curriculum essential for accreditation. Initially we hope to provide 28 third-year students for the program. Since some students from the CMDNJ-Rutgers Medical School are forced to leave the state because of the absence of a teaching hospital on the Piscataway campus, early classes in the South Jersey program could consist of these individuals. We expect the program to be in full operation by 1982.

While professional support for our efforts in South Jersey is deeply appreciated, it is the non-professional support that has given us the added push necessary, not only to demonstrate the need for the program but also to put it across. The enthusiasm of the community has been reflected in our Community Advisory Council, chaired by Arthur H. Galipeau. The appreciation of the medical profession of New Jersey is extended to all who have worked with us and who will work with us once the program is underway.

June 4-8, 1976
MSNJ Annual Meeting

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY — Howard C. Rothman, M.D., 435 East 70th Street, New York 10021. Cincinnati 1970. Board certified (medicine). Group or partnership. Available July 1976.

Ibrahim A. Sarris, M.D., 6511 Landover Road, Apt. 204, Cheverly, Maryland 20785. El-Azhar (Egypt) 1970. Board eligible. Group, partnership, associate, solo. Available July 1976.

FAMILY PRACTICE — Daniel M. Blumkin, M.D., 330 Norwalk Road, Springfield, Illinois 62704. Rochester 1973. Group. Available July 1976.

Hasmukh P. Patel, M.D., 1/1B, 21 Walnut Road, Glen Cove, New York 11542. B.J. Medical (India) 1970. Group partnership. Available July 1976.

Michael G. Maroldo, M.D., 304 Elsmere Street, Wilmington, Delaware 19804. Wayne State 1974. Group or partnership. Available July 1976.

GENERAL PRACTICE — Leonard S. Spoto, Jr., M.D., 1929 Sioux, Glendale, Arizona 85307. Wake Forest 1971. Group (no OB). Available July 1976.

Nellie Lee, M.D., 175 Hobart Street, Ridgefield Park, New Jersey 07660. Far Eastern (Philippines) 1966. Subspecialty, cardiology. Board certified. Group, partnership, clinic, or solo. Available.

Leslie C. Feigin, M.D., 361 Park Ave., Apt. B-2, Orange, New Jersey 07050. CMDNJ 1973. Board eligible. Group or partnership in northern New Jersey. Available July 1976.

Ishwar V. Thakkar, M.D., 1926 West Harrison Street, Apt. 1110, Chicago 60612. Baroda (India) 1970. Subspecialty endocrinology. Board eligible. Group, associate with teaching hospital. Available July 1976.

INTERNAL MEDICINE — Bernard M. Aaron, M.D., 200 Flower Drive, Lexington Park, Maryland 20653. SUNY — Downstate 1969. Subspecialty, gastroenterology. Board certified. Group or partnership as gastroenterologist. Available July 1976.

John E. Madsen, Jr., M.D., 135 Florence Road, Apt. 2C, Branford, Connecticut 06405. Cornell 1968. Subspecialty, gastroenterology. Board certified. Partnership, group, or hospital-based practice. Available.

K. S. Lakshmi Narayanan, M.D., 27300 Parkview Blvd., Apt. 7308, Warren, Michigan 48092. Stanley (India) 1970. Subspecialty, gastroenterology. Board eligible. Group or partnership. Available July 1976.

Dennis Gort, M.D., 822 President Street, Apt. 4, Brooklyn, New York 11215. SUNY, Downstate 1972. Subspecialty, pulmonary medicine. Board certified. Group or institutional. Available July 1976.

Wilhelmina M. Cruz, M.D., 495 East Seventh Street, Apt. 6D, Brooklyn, New York 11218. Santo Tomas (Manila). Subspecialty, nephrology. Board eligible. Dialysis or hypertension program with opportunity for private practice in group, partnership or solo. Available.

Kevoek Cileli, M.D., 1311 Palisade Avenue, Fort Lee 07024. Ankara 1957. Board eligible. Partnership or solo. Available August 1976.

Jung-San Shen, M.D., 377 S. Harrison Street, Apt. 16-W, East Orange 07018. Kaohsiung Medical (Taiwan) 1968. Board eligible. Subspecialty, pulmonary diseases. Solo, group, or hospital. Available July 1976.

Manoj Desai, M.D., 48-56 44th Street, Woodside, New York 11377. B.J. Medical (India) 1969. Board eligible. Subspecialty, oncology. Group, partnership, or hospital. Available July 1976.

Chau-Fe Huang, M.D., 245-01 75th Avenue, Glen Oaks, New York 11004. Chungshan Medical (Canton, China) 1966. Board certified. Subspecialty, cardiology. Group or partnership. Available July 1976.

Daniel Markowitz, M.D., 785 Skynob Drive, Ann Arbor, Michigan 48105. Einstein 1971. Board certified. Subspecialty, pulmonary diseases. Group, partnership, or hospital. Available July 1976.

William W. Tan, M.D., 250 Mt. Vernon Place, Apt. 2-H, Newark 07106. Indonesia 1964. Board eligible. Subspecialty, cardiology. Group, partnership, solo, or hospital. Available July 1976.

Leslie C. Feigin, M.D. 361 Park Ave., Apt. B2, Orange, N.J. 07050. CMDNJ 1973. Board eligible. Group or partnership in northern New Jersey. Available July 1976.

OBSTETRICS AND GYNECOLOGY — Murray R. Master, M.D., Box 155, Barnes Hospital, St. Louis, Missouri 63110. Pennsylvania State 1973. Board eligible. Group or partnership. Available July 1976.

Stephen M. Woodruff, M.D., 1426 Avon Place, Pittsburgh, Pennsylvania 15221. Jefferson 1970. Board Eligible. Group or partnership in mid or southern New Jersey. Available July 1976.

Fa-Tsair Shieh, M.D., 412 West 115th Street, Apt. 2-W, New York 10025. China (Taiwan) 1970. Board eligible. Group, partnership, or solo. Available July 1976.

Jiunn S. Cheng, M.D., 1757 East Raleigh Court, Apt. 168-A, Ocean, New Jersey 07712. Kaohsiung Medical (Taiwan) 1964. Board eligible. Solo or group.

OPHTHALMOLOGY — Richard L. Tax, M.D., 1605 Park Towne Place, Philadelphia, Pennsylvania 19130.

Cornell 1970. Board eligible. Group, partnership, or solo. Available June 1976.

Alan L. Schein, M.D., 119 Upland Terrace, Bala-Cynwyd, Pennsylvania 19004. Jefferson 1969. Board eligible. Group or partnership. Available July 1976.

Ghulam Dastgir, M.D., 614 Troy Avenue, Brooklyn, New York 11203. King Edward, Lahore (Pakistan) Board eligible. Group or partnership. Available July 1976.

ORTHOPEDIC SURGERY — Alfred G. Krebs, M.D., 666 Massachusetts Avenue, Acton, Massachusetts 01720. Jefferson 1969. Board eligible. Group, partnership, or solo. Available July 1976.

PEDIATRICS — Lawrence Schaffer, M.D., 3726 Lankenau Road, Philadelphia, Pennsylvania 19131. Einstein 1971. Group, partnership, or solo. Available July 1976.

M. Patricia Fiorentino Baran, M.D., 7603 Foxhall Lane, Richmond, Virginia 23228. SUNY Downstate 1972. Board eligible. Group. Available July 1976.

John Motley, M.D., 103 Poplar Lane, Lexington Park, Maryland 20653. Jefferson 1971. Board eligible. Group or partnership (willing to purchase). Available July 1976. Telephone (301) 862-3525

Waled H. Chowdhury, M.D., 53 Linden Avenue, Irvington 07111. Dacca Medical (Bangladesh) 1970. Board eligible. Solo or partnership. Available July 1976.

PLASTIC SURGERY — Mark B. Handler, M.D., 2417 Hempstead Road, Toledo, Ohio 43606. Dalhousie (Nova Scotia) 1969. Board eligible. Partnership or group. Available July 1976.

RADIOLOGY — Robert J. Baran, M.D., 7603 Foxhall Lane, Richmond, Virginia 23228. SUNY Downstate 1972. Board eligible. Group or hospital based. Available July 1976.

SURGERY — Dara Vahid, M.D., 200 Carman Avenue, #12D, East Meadow, New York 11554. University of Tehran (Iran) 1964. Board eligible. Group or partnership. Available July 1976.

Elmer D. Geniblazo, M.D., 184 Estaban Drive, Camarillo, California 93010. Far Eastern 1962. Group, solo — will consider general practice. Available November 1975.

Narasimha S. Rao, M.D., 9601 Ashton Road, Apt. N-5, Philadelphia 19114. Osmania (India) 1963. Board eligible. Subspecialty, vascular surgery. Group, partnership, solo, or associate. Available July 1976.

J. Gerard Crowley, M.D., 333 East 34th Street, New York 10016. Dublin (Ireland) 1965. Board eligible. Subspecialty, peripheral vascular surgery. Partnership. Available July 1976.

Walid A. Khuri, M.D., 200 Washington Square, Richlands, Virginia 24641. American University (Beirut) 1966. Board certified. Group, partnership, associate, solo, hospital. Available January 1976.

William Doscher, M.D., 2500 Johnson Ave., Riverdale, New York 10463. SUNY 1968. Board certified. Subspecialty, vascular surgery. Group, partnership, or hospital. Available July 1976.

UROLOGY — Bernard Schaaf, M.D., 1000 Langworthy, Dubuque, Iowa 52001. Washington University (St. Louis) 1962. Board certified. Partnership or group. Available March 1976.

Kasturi G. Shanker, M.D., 101-4 Van Buren Road, Voorhees 08043. Madras (India) 1960. Group, partnership, solo, or hospital-based. Available July 1976.

Richard A. Fraser, M.D., 15 Rose Loop, Fort Leavenworth, Kansas 66027. St. Louis 1969. Board eligible. Group, partnership, or academic. Available July 1976.

210th Annual Meeting

June 4-8, 1976

Cherry Hill Hyatt House

New Challenges in Medicine*

Why all this emphasis on continuing education, on refresher courses, on re-examinations? Do we really have to go through additional reviews, evaluations, re-certifications? Can't we just go out and practice what we have learned?

Five hundred years ago and even a hundred and fifty years ago the answer to that last question would have been a qualified "yes." There was at each of those times a distinct, established, and recognized body of medical knowledge that could be assimilated during the prescribed course of studies. After that, the erstwhile student, now a physician, went out and practiced (i.e., put to practical use) what had been preached to him.¹ Continued contact with fellow physicians was ensured early through the guild system; in later periods, this was accomplished through professional societies. It didn't really matter that the new physician kept continued close contact with his university or with his teachers. Knowledge increased slowly. Such advances as were made had little to do with the practice of medicine and much to do with public health matters such as sanitary engineering, nutrition, and housing on the one hand and with the basic sciences such as anatomy, physiology, and chemistry on the other. Only the middle and upper classes, the bourgeoisie and the nobility, could afford the services of physicians whose contributions were in any event limited. Indeed, physicians more often contributed to the disease of their patients through enemas, bleedings and a weird collection of decoctions, inunctions, and emulsions. Many times cries were heard, but not always heeded, that the treatment was worse than the illness.

In this connection, let me cite to you the totally unreliable testimony of a witness to the scene of nearly two centuries ago. I refer here to the memoirs of a certain Baron Munchausen² whose name has in recent years been used to grace a syndrome with which you should be familiar. The Baron had been playing tricks in England with a balloon of his design and was involved in a number of unusual escapades. Here is the story of one such escapade.

"On the 30th of September, when the College of Physicians chose their annual officers, and dined sumptuously together, I filled my balloon, brought it over the dome of their building, clapped the sling around the golden ball at the top, fastened the other end of it to the balloon and immediately ascended with the whole college to an immense height, where I kept them upwards of three months. You will naturally inquire what they did for food such a length of time? To this I answer, had I kept them suspended twice the time, they would have experienced no inconvenience on that account, so amply, or rather extravagantly, had they spread their table for that day's feasting.

"Though this was meant as an innocent frolic, it was productive of much mischief to several respectable characters amongst the clergy, undertakers, sextons, and grave-diggers: they were, it must be acknowledged, sufferers; for it is a well-known fact, that during the three months the college was suspended in the air, and therefore incapable of attending their patients, no deaths happened, except a few who fell before the scythe of Father Time, and some melancholy objects who, perhaps to avoid some trifling inconvenience here, laid the hands of violence upon themselves, and plunged into misery infinitely greater than that which they hoped by such a rash step to avoid, without a moment's consideration.

"If the apothecaries had not been very active during the above time, half the undertakers in all probability would have been bankrupts."

Quite an indictment. Nonetheless, the profession has survived this and other attacks and has obviously prospered. Why? I suggest that it was because of the understanding, support, and compassion that physicians brought to the sick. It was his talent in listening, the advice and guidance given, the reassurance based on experience of a favorable outcome, even the indication that death was near that made the physician important and useful. This occurred despite his inability to modify significantly the course of the illness of his patients in most instances.

The setting and the scene have changed dramatically in the past hundred and fifty years and particularly in the past fifty years. Medicine has progressed at a fantastic rate. With this explosion of knowledge, the physician has been able to modify the course of illness and disease while his (today add "and her") confrères in preventive medicine and public health have been

*This commentary is based on an address to the graduating house staff at St. Joseph's Hospital, Paterson, June 12, 1975, by Francis P. Chinard, M.D., Professor of Experimental Medicine, New Jersey Medical School, CMDNJ.

able to come close to the eradication of some of the infectious diseases that used to plague mankind. Thus, the attention of a physician, once a luxury, and an ineffective one at that, has become the means for survival, the means for functioning at a tolerable or bearable level of disease, and the means of quick and effective management of many acute illnesses.

Whether one does or does not have a physician increasingly makes a difference. Those economic and social classes that have not had access to physicians in the past did not miss very much; they used the hospitals as places of last resort. This was the role played typically by municipal hospitals. These were the places where one went to die; these were the charnel houses; these were the butcher shops and slaughter houses of old, the old Bellevues, the old Charité hospitals, the Hotel-Dieu hospitals — so appropriately named since so many patients went there on the way to meet their maker. The more affluent classes also died just as surely but at home and, admittedly, sometimes with an assist from their physicians on the way to their final reward.

Nowadays, many will recognize the situation as being quite otherwise. Having a physician does make a difference in the eyes of the disadvantaged and more affluent. The demand is as much for *physicians* as for *medical care* which can be delivered anonymously. Even affluent suburbia demands, with decreasing success, the services of a physician identified as belonging in part to the patient: "my physician, my doctor." The disadvantaged classes of society, which are hopefully now on the way up, will not be satisfied just with medical care at a level of excellence that is now available to the affluent. What is sought and desired is the service, the attention, and the understanding of a physician in addition to high quality medicine.

I have already suggested the basis for this continued survival of the medical profession and of physicians. It is the human aspect of medicine — the understanding, the compassion, and the support that many seek in us — that has made for our survival. For the physical aspects of medicine, physicians with breadth of knowledge and understanding are not necessary. The ex-

perience of individual physicians, gained over many years of dealing with human problems, is not a requisite for the diagnosis and handling of a *case* of essential hypertension. Notice that I said *case*, not *patient*, not *human being*. Yes, there are areas in which special technical skills are required, such as in the manipulative disciplines where surgical procedures are carried out. But haven't we heard of non-physicians doing emergency operations, refined skills learned by technicians, nurse anesthetists, and midwives?

We are now stressing the scientific advances of medicine, and the sophistication of diagnostic and therapeutic modalities. We have evolved super-specialists whose technical abilities may be unsurpassed but whose humanistic capabilities are sometimes lower than those of an oyster. This is a fantastic switch and, if the medical profession continues in this direction, it may well have to pay with its own destruction as the price. A terrible vengeance will have been exacted by society. It is appropriate that one of the most severe critics of modern medicine, Ivan Illich, has titled his latest diatribe *Medical Nemesis*.³ "Nemesis" is the name given to the Greek goddess of vengeance. Here follow a few sentences from the introduction:

"The medical establishment has become a major threat to health. Dependence on professional health care affects all social relations. In rich countries, medical colonialization has reached sickening proportions; poor countries are quickly following suit. This process, which I shall call the 'medicalization of life' deserves articulate political recognition.

"A professional and physician-based health care system which has grown beyond tolerable bounds is sickening for three reasons: it must produce clinical damages which outweigh its potential benefits; it cannot but obscure the political conditions which render society unhealthy; and it tends to expropriate the power of the individual to heal himself and to shape his or her environment."

There is still time to change our direction and to avoid the retribution that society may well decide to wreak on us if we do not. There are suggestions that this change will occur.

In an editorial on the changing climate of medicine, Philip Abelson, editor-in-chief of *Science*, remarked on the stresses our profession is enduring.⁴ Medicare, Medicaid, the fracas

over malpractice insurance, the demands for more physicians, the demands for greater availability of medical care, the demands for perfection on the part of all members of the profession are some of the stresses. Abelson makes two points. The first is that "the essence of the practice of medicine is in the interaction between patient and physician." I've tried to emphasize that here. But that essence, that quality, as much in demand as it is today, can be lost if we as a profession and as individual physicians do not strive to preserve and even more importantly to enhance it. We *are* today in danger of losing that essence and if we lose that we will have lost our reason for existence.

Abelson's second point is that physicians have conscience and motivation and that these characteristics must also be preserved. To that point also I would say "Amen." Not only must they be preserved, they too must be enhanced.

The generation now beginning the practice of medicine is confronted with many problems. One is the changing face and content of medicine with the need for continued learning and assimilation of the new knowledge that is added every day. Another problem is represented by the demands of an increasingly dissatisfied

public which is uncertain of what it wants. A third is the review and evaluation (surveillance is the appropriate term here) of physician performance and the increasing demand for perfection in our profession in an otherwise imperfect world.

I would suggest that our young physicians view all these as challenges rather than as problems. I hope that they will enjoy the profession of medicine in all of its aspects as much as their predecessors have and certainly as my generation has. I hope that they will not get discouraged because of the stresses. One thing I can guarantee — they will never die of boredom.

Francis P. Chinard, M.D.

References

¹Folkman J: For doctors, a little practice is a dangerous thing. *New York Times*, June 6, 1975. p. 33.

²Raspe A: *The Memoirs of the Baron Munchausen*. New York, Dover Press, 1956. p. 59.

³Illich I: *Medical Nemesis*. London, Calder & Boyars Ltd., 1975. p. 11.

⁴Abelson PH: Changing climate for medicine. *Science* 188: 975, 1975.

LETTERS TO THE JOURNAL

Marihuana Laws

October 27, 1975

Dear Editor:

In these days of existentialism when reason, both abstract and empirical, is rejected and discarded and common sense is frequently ignored, it is gratifying and encouraging to read Martin E. Johnson's commentary on marihuana.

The drive to liberalize the laws on marihuana and hashish appears to have a very potent lobby

in its favor. The liberalization proposed in Senator Menza's report to the New Jersey legislature will only serve to intensify the whole problem of drug abuse.

Mr. Johnson's article on this subject is both factual and realistic and I wish to commend him for his courage in writing it. Credit should also go to you and the Society for publishing it. I have written to Senator Menza on two previous occasions protesting the "decriminalization" of marihuana usage. Drug abusers do not operate in a vacuum; they contribute to the spread of their habits.

Again I thank you for the great service you have rendered by publishing this commentary.

(signed) Henry D. Chieffo, M.D.

ANNOUNCEMENTS

Pediatric Arthritis Clinics

Under the auspices of the Greater Delaware Valley Regional Medical Program, demonstration clinics in pediatric arthritis will be conducted by the staff of the connective tissue clinic at the Children's Seashore House in Atlantic City from 9:45 to 11:45 a.m. on the dates listed:

December 17	Differential Diagnosis of Arthritis
February 18	Treatment of Arthritis
April 21	Arthritis in Children

Prior registration is required and admittance is limited to six physicians at each session. Two hours of AMA Category I accreditation will be awarded to those in attendance. Please call or write to B. H. Athreya, M.D., Children's Seashore House, 4111 Atlantic Avenue, Atlantic City 08401 — (609) 345-5191 — for information.

Pulmonary Disease Series

Following is a list of the monthly lectures in pulmonary diseases to be sponsored jointly by the Veterans Administration Hospital in East Orange and the New Jersey Medical School in Newark:

Dec.	17—Mechanisms of Lung Injury in Obstructive Lung Disease
Jan.	21—Interstitial Disease of the Lung
Feb.	18—Protease Inhibitors and Pulmonary Disease
Mar.	17—Pulmonary Cardiogenesis
Apr.	21—Categories of Pulmonary Disease Measured by Functional and Laboratory Data
May	12—Rehabilitation of Chronic Pulmonary Patient

All sessions will be held at 11:30 a.m. in the third-floor auditorium of the East Orange Veterans Administration Hospital. For additional information, please communicate with L. Fred Ayvazian, M.D., Chief of the Pulmonary Disease Section at the hospital.

Postgraduate Medical Congress in Nassau

The first American-German Postgraduate Medical Congress will be held from December 26, 1975 to January 9, 1976, in Nassau, the Bahamas. Faculty from United States and Ger-

man universities (all bilingual) will participate in teaching seminars structured for practicing internists, cardiologists, and family physicians. Arrangements have been made for a cruise of the Caribbean following the close of the sessions. Additional details may be obtained from S. Heyden, M.D., Professor of Community Health Sciences, Duke University Medical Center, Durham, North Carolina 27710.

Surgical Lectures — Rutgers Medical School

The Rutgers Medical School, CMDNJ, Department of Surgery, announces the following final program in its series of lectures, which are approved for one credit-hour each in Category I of the AMA Physician's Recognition Award:

January 6	<i>Renovascular Hypertension</i> William J. Fry, M.D., Professor of Surgery University of Michigan Medical School
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All lectures will be held at 5 p.m. in the main auditorium of Rutgers Medical School, University Heights, Piscataway. For further information please communicate with John H. Landor, M.D., Professor and Chief of the Division of General Surgery at the College.

Programs on Dermatology

The New Jersey Dermatological Society has announced the following program schedule for 1975-1976:

November 11	Case Presentations and Discussion Charles DeFeo, M.D. NYU School of Medicine
January 13	Photosensitivity Diseases Leonard Harber, M.D. Columbia University College of Physicians and Surgeons
February 10	Pseudo Tumors — 1976 Update A. Bernard Ackerman, M.D. NYU School of Medicine
March 9	Collagen Diseases and Vasculitis Irwin M. Braverman, M.D. Yale University School of Medicine
April 13	Clinical Pathological Conference Lewis Shapiro, M.D. Columbia University College of Physicians and Surgeons

May 11 Dinner Meeting
(details to be announced later)

The meetings are held at 8 p.m. on the dates indicated — in November at the St. Barnabas Medical Center in Livingston; in January, February, and March at Schering Corporation in Kenilworth; and in April at Johnson and Johnson in New Brunswick. For details please communicate with the Secretary of the New Jersey Dermatological Society, Robert M. Fischbein, M.D., 512 East Broad Street, Westfield 07090.

OB/GYN — Surgery Questionnaire Course

The Section on Surgery and the Section on Obstetrics and Gynecology of The Medical Society jointly will sponsor a questionnaire course, the responses to which will be presented at a seminar on Monday, June 7, 1976 during the 210th annual meeting of MSNJ. Topic to be considered is abdominal sepsis and a questionnaire on that subject will be circulated among those who are interesting in participating. Please send a stamped, self-addressed envelope (#10) to Eric J. Lazaro, M.D., Professor of Surgery, New Jersey Medical School, CMDNJ, 65 Bergen Street, Newark, New Jersey 07107, with the notation "questionnaire course" written in pencil on the flap. Deadline for receipt of this

envelope is *February 27, 1976*. There is no fee and the program carries four AMA category I credits.

Aspen Radiology Conference

The sixth annual Aspen Radiology Conference will be held from March 1 to 5, 1976, at the Aspen Institute for Humanistic Studies, Aspen, Colorado. It is designed for physicians and scientists interested in diagnostic radiology, nuclear medicine, and radiation therapy, and will explore the impact of clinical and technological advances on radiologic practice. Additional information may be obtained from Emanuel Salzman, M.D., Conference Chairman, Division of Radiology, Beth Israel Hospital, Denver, Colorado 80204.

Back Issue of JAMA Needed

Copies of the August 2, 1947, issue of *JAMA* (Vol. 134), which contains an article about General Custer, are needed for purposes of historical research. If your library includes this copy and you are willing to donate it, please send it to *The Journal*, MSNJ, PO Box 904, Trenton, New Jersey 08605, and we will see that whatever is received is forwarded.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Dec.

— Every Weekday Conferences

12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice Residency Program and AAFP)

— General Surgery Continuing Education

3 p.m. (every Monday, Thursday, Friday) — Atlantic City Hospital
(Sponsored by Atlantic City Hospital)

13 Aneurysms of Aorta and Lower Extremities

10-11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)

13 Advances in Orthopedic Surgery

20 8:30-11:30 a.m. — CMDNJ, New Jersey Medical School, Newark

27 School, Newark

(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)

13 Seminary on Antimicrobial Therapy

8 a.m.-5 p.m. — Holiday Inn, Jersey City
(Sponsored by Hudson County Medical Society and Academy of Medicine)

15 Pediatric Happenings

22 12:30 p.m. — Overlook Hospital, Summit
29 (Sponsored by Overlook Hospital, and AAFP)

- 15 Distinguished Lectures in Surgery
- 22 4-5 p.m. — Martland Hospital Unit, Newark
- 29 (*Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine*)
- 15 Joint Neurological-Neurosurgical Conferences
- 11:30 a.m. — Pascack Valley Hospital, Westwood
- (*Sponsored by Pascack Valley Hospital and Academy of Medicine*)
- 15 Clinical Aspects of Colonic Cancer
- 12 noon-1 p.m., — Montclair Community Hospital
- (*Sponsored by Montclair Community Hospital and Academy of Medicine*)
- 16 Psychiatric Case Conferences
- 23 7:30 a.m. — Trenton Psychiatric Hospital
- 30 (*Sponsored by Trenton Psychiatric Hospital and Academy of Medicine*)
- 16 Topics in Neurosurgery
- 23 4-5 p.m. — VA Hospital, East Orange
- 30 (*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine*)
- 16 Survey of Allergy-Immunology
- 11 a.m. — St. Elizabeth Hospital, Elizabeth
- (*Sponsored by Elizabeth Tri-Hospital Residency Program and AAFP*)
- 16 Medications in Treating Arrhythmias
- 23 8 a.m. — Overlook Hospital, Summit
- (*Sponsored by Overlook Hospital and AAFP*)
- 16 Sports Medicine
- 11:30 a.m. — St. Mary's Hospital, Orange
- (*Sponsored by St. Mary's Hospital and Academy of Medicine*)
- 16 Chondromalacia
- 5 p.m. — St. Mary's Hospital, Orange
- (*Sponsored by St. Mary's Hospital and Academy of Medicine*)
- 16 Radiology of Genitourinary Disease
- 7-9:30 p.m. — VA Hospital, East Orange
- (*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine*)
- 17 Cardiopulmonary Resuscitation
- 2:30 p.m. — Trenton Psychiatric Hospital
- (*Sponsored by Trenton Psychiatric Hospital and Academy of Medicine*)
- 17 Acute Abdominal Trauma and Peritoneal Lavage as Diagnostic Tool
- 1 p.m. — Christ Hospital, Jersey City
- (*Sponsored by Christ Hospital and AAFP*)
- 17 Recent Advances in Pulmonary Disease
- 11:30 a.m. — VA Hospital, East Orange
- (*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine*)
- 17 Special Problems in Neurology
- 7 p.m. — VA Hospital, East Orange
- (*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine*)
- 17 Recognition and Treatment of Hemorrhagic Disorders in the Surgical Patient
- 7 p.m. — Englewood Men's Club
- (*Sponsored by Englewood Surgical Society and Academy of Medicine*)
- 17 Dermatologic Signs of Systemic Disease
- 9 a.m. — West Jersey Hospital, Voorhees
- (*Sponsored by West Jersey Hospital and AAFP*)
- 17 Medical Lecture Series
- 9-11 a.m. — Riverview Hospital, Red Bank
- (*Sponsored by Riverview Hospital and Academy of Medicine*)
- 17 Review of Internal Medicine
- Sheraton Inn, Newark Airport, Elizabeth
- (*Sponsored by Academy of Medicine and CMDNJ*)
- 17 Psychiatric Aspects of Criminology
- Part I and Part II
- 3-4:30 p.m. — Fair Oaks Hospital, Summit
- (*Sponsored by Fair Oaks Hospital and Academy of Medicine*)
- 17 Advances in Medicine
- 24 9:30 a.m. — Bergen Pines County Hospital, Paramus
- (*Sponsored by Bergen Pines County Hospital and Academy of Medicine*)
- 17 Perinatal Seminars
- 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
- (*Sponsored by Newark Beth Israel Medical Center and Academy of Medicine*)
- 17 Conferences in Endocrinology
- 3:30-5 p.m. — Location to be announced
- (*Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, Newark Beth Israel Medical Center, and Academy of Medicine*)
- 17 Current Topics in Psychiatry
- 3 p.m. — Fair Oaks Hospital, Summit
- (*Sponsored by Fair Oaks Hospital and Academy of Medicine*)
- 17 Cardiology Conferences
- 4-5:30 p.m. — CMDNJ, Rutgers Medical School
- (*Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine*)
- 17 Family Practice Multidiscipline Conference
- 12:30 p.m. — Overlook Hospital, Summit
- (*Sponsored by Overlook Hospital and AAFP*)
- 17 Recent Trends in Genetics
- 9-11 a.m. — Middlesex General Hospital, New Brunswick
- (*Sponsored by Middlesex General Hospital and Academy of Medicine*)
- 18 Advances in Immunology
- 4-6 p.m. — Institute for Medical Research, Camden
- (*Sponsored by Institute for Medical Research and AAFP*)
- 18 Continuing Medical Education Programs
- 11 a.m. — John F. Kennedy Medical Center, Edison
- (*Sponsored by John F. Kennedy Medical Center and Academy of Medicine*)

- 18 **New Concepts in Pyelonephritis**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 18 **To Be Announced**
4-5:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital)
 - 19 **Pediatric Endoscopy**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 19 **Family Practice Seminars**
12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
 - 19 **Coronary Heart Disease**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 23 **Family Practice/Psychiatric Case Presentations**
12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
 - 23 **Immunologic Principles in Laboratory Procedures**
12 noon — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania)
 - 24 **Basic Electrocardiography**
7:30 a.m. — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center and AAFP)
 - 30 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- Jan.**
- **Every Weekday Conferences**
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center Family Practice Residency Program and AAFP)
 - **General Surgery Continuing Education**
3 p.m. (every Monday, Thursday, Friday) — Atlantic City Hospital
(Sponsored by Atlantic City Hospital)
 - 3 **Advances in Orthopedic Surgery**
10 8:30-11:30 a.m. — CMDNJ, New Jersey Medical
17 School, Newark
24 (Sponsored by CMDNJ-New Jersey Medical School
31 and Academy of Medicine)
 - 5 **Headache**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)
 - 5 **Neonatal Emergencies**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
 - 5 **Distinguished Lectures in Surgery**
12 4-5 p.m. — Martland Hospital Unit, Newark
19 (Sponsored by CMDNJ-New Jersey Medical School
26 and Academy of Medicine)
 - 5 **Pediatric Happenings**
12 12:30 p.m. — Overlook Hospital, Summit
19 (Sponsored by Overlook Hospital and AAFP)
26
 - 6 **Diabetes**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
 - 6 **Recognition and Management of Depressive State**
12 noon — Hospital Center at Orange
(Sponsored by Hospital Center at Orange and Academy of Medicine)
 - 6 **Family Practice/Psychiatric Case Presentations**
12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
 - 6 **Psychiatric Case Conferences**
13 7:30 p.m. — Trenton Psychiatric Hospital
20 (Sponsored by Trenton Psychiatric Hospital and
27 Academy of Medicine)
 - 6 **Topics in Neurosurgery**
13 4-5 p.m. — VA Hospital, East Orange
20 (Sponsored by CMDNJ-New Jersey Medical School,
27 VA Hospital, and Academy of Medicine)
 - 7 **Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by Academy of Medicine and CMDNJ-New Jersey Medical School)
 - 7 **Management of Hepatitis**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)
 - 7 **Hypertension**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
 - 7 **Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 7 **Perinatal Seminars**
14 9:30 a.m.-2 p.m. — Newark Beth Israel Medical
21 Center
28 (Sponsored by Newark Beth Israel Medical Center and Academy of Medicine)
 - 7 **Conferences in Endocrinology**
14 3:30-5 p.m. — Location to be announced
21 (Sponsored by CMDNJ-New Jersey Medical School,
28 VA Hospital, East Orange, Newark Beth Israel Medical Center and Academy of Medicine)
 - 7 **Cardiology Conferences**
21 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School, Academy of Medicine of N.J.)
 - 7 **Clinical Applications of Liver Physiology**
14 **Respiratory Failure**
21 **Recognition and Management of Heart Failure**
28 **Fluid and Electrolyte Problems in Pediatric Practice**

- 9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
- 7 Medical Lecture Series
14 9-11 a.m. — Riverview Hospital, Red Bank
21 (Sponsored by Riverview Hospital and
28 Academy of Medicine)
- 7 Basic Electrocardiography
21 7:30 a.m. — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center and AAFP)
- 8 Internal Medicine/Family Medicine Visiting
22 Professorships
12 noon-1 p.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 8 Diagnosis and Treatment of Shock
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 8 Pre-eclampsia
11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 8 Advances in Immunology Course
15 4-6 p.m. — Institute for Medical Research, Camden
22 (Sponsored by Institute for Medical Research and
29 Academy of Medicine)
- 9 Family Practice Seminars
16 12:30 p.m. — Overlook Hospital, Summit
23 (Sponsored by Overlook Hospital and AAFP)
30
- 9 Renal Symposium
9 a.m.-5 p.m. — CMDNJ, New Jersey Medical School, Newark
(Sponsored by CMDNJ-New Jersey Medical School, N.J. RMP, Ruth Gottsche Kidney Foundation, Nephrology Society of New Jersey and Academy of Medicine)
- 9 Monthly Scientific Meeting
8:30 p.m. — Hackensack Hospital
(Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine)
- 9 Obstructive Lung Disease
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 13 Photosensitivity Diseases
8 p.m. — Schering Corporation, Kenilworth
(Sponsored by Academy of Medicine and New Jersey Dermatological Society)
- 13 Thyroid Diseases
10 a.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of Medicine)
- 13 Infectious Diseases
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)
- 13 Proper Use of Antibiotics
9 p.m. — West Hudson Hospital, Kearny
(Sponsored by West Hudson Hospital and Academy of Medicine)
- 14 Anesthesia Conference
8-9:30 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
- 14 Monthly Neuro-Radiology Meetings
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)
- 14 Gastrointestinal Bleeding
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by John E. Runnells Hospital and Academy of Medicine)
- 14 Diagnosis and Monitoring of Shock
21 Mitral Valve Disease
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 14 Family Practice Multidiscipline Conference
28 12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital, and AAFP)
- 16 Medical Management of the Complications of Pregnancy
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
- 16 Airway Obstruction in Infants and Children
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 17 New Nutrition-Protocols and Problems
10-11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 19 Medical Lecture Series
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 20 Joint Neurological-Neurosurgical Conferences
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
- 20 Radiology of Genitourinary Disease
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital and Academy of Medicine)
- 20 Cardiac Rehabilitation
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
- 20 Acupuncture
8 p.m. — Ramada Inn, Clark
(Sponsored by New Jersey Society of Anesthesiologists and Academy of Medicine)

- 21 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
- 21 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital and Academy of Medicine)
- 21 **Proper Use of Endoscopy**
1 p.m. — VA Hospital, Lyons
(Sponsored by VA Hospital and Academy of Medicine)
- 21 **Psychiatry-Group Therapy**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 21 **Proper Use of Blood Gases**
2 p.m. — Cherry Hill Medical Center
(Sponsored by Cherry Hill Medical Center and Academy of Medicine)
- 22 **Hypersensitivity Lung Disease**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 22 **Pulmonary Sarcoidosis**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
- 26 **Neonatal Emergencies**
11:30 a.m. — Helene Fuld Hospital, Trenton
(Sponsored by Helene Fuld Hospital and Academy of Medicine)
- 27 **Medical-Legal Aspects of Medicine and Surgery**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
- 27 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 28 **Echocardiography in Assessment of Patient with Coronary Artery Disease**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 30 **Proper Use of Endoscopy**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- Feb.
- **General Surgery Continuing Education**
3 p.m. (every Monday, Thursday, Friday) — Atlantic City Hospital
(Sponsored by Atlantic City Hospital)
- 2 **Diagnosis of the Anemic Patient**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
- 2 **Cerebral Vascular Disease**
1 p.m. — Ancora Psychiatric Hospital
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)
- 2 **Pediatric Happenings**
9 12:30 p.m. — Overlook Hospital, Summit
16 (Sponsored by Overlook Hospital and AAFP)
23
- 2 **Distinguished Lectures in Surgery**
9 4-5 p.m. — Martland Hospital Unit, Newark
16 (Sponsored by CMDNJ-New Jersey Medical School
23 and Academy of Medicine)
- 3 **Family Practice/Psychiatric Case Presentations**
12:30 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 3 **Laboratory Interpretations**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
- 3 **Psychiatric Case Conferences**
10 7:30 a.m. — Trenton Psychiatric Hospital
17 (Sponsored by Trenton Psychiatric Hospital
24 and Academy of Medicine)
- 3 **Topics in Neurosurgery**
10 4-5 p.m. — VA Hospital, East Orange
17 (Sponsored by CMDNJ-New Jersey Medical School,
24 VA Hospital and Academy of Medicine)
- 4 **Laboratory Interpretations**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)
- 4 **Malpractice**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 4 **Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 4 **Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 4 **Medical Lecture Series**
11 9-11 a.m. — Riverview Hospital, Red Bank
18 (Sponsored by Riverview Hospital and
25 Academy of Medicine)
- 4 **Electrolyte Problems in the Aged**
11 **Food Faddism and Hypervitaminosis**
18 **Obesity-Fact and Fantasy**
25 **Abnormal Uterine Bleeding**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

- 4 **Conferences in Endocrinology**
- 11 3:30-5 p.m. — Location to be announced
- 18 *(Sponsored by CMDNJ-New Jersey Medical School,*
- 25 *VA Hospital, Newark Beth Israel Medical Center, and*
Academy of Medicine)
- 4 **Perinatal Seminars**
- 11 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
- 18 *(Sponsored by Newark Beth Israel Medical Center and*
- 25 *Academy of Medicine)*
- 4 **Cardiology Conferences**
- 18 4-5:30 p.m. — CMDNJ, Rutgers Medical School
- (Sponsored by CMDNJ-Rutgers Medical School and*
Academy of Medicine)
- 4 **Basic Electrocardiography**
- 7:30 a.m. — Hunterdon Medical Center, Flemington
- (Sponsored by Hunterdon Medical Center and AAFP)*
- 4 **The Pancreas (Albert Siegel Memorial Symposium)**
- Details later
- (Sponsored by the Academy of Medicine)*
- 5 **Advances in Immunology**
- 12 4-6 p.m. — Institute for Medical Research, Camden
- 19 *(Sponsored by Institute for Medical Research*
26 *and AAFP)*
- 6 **Malpractice**
- 8:30 a.m. — United Hospitals of Newark
- (Sponsored by United Hospitals of Newark and*
Academy of Medicine)
- 6 **Family Practice Seminars**
- 13 12:30 p.m. — Overlook Hospital, Summit
- 20 *(Sponsored by Overlook Hospital and AAFP)*
- 27
- 7 **Advances in Orthopedic Surgery**
- 14 8:30-11:30 a.m. — CMDNJ, New Jersey Medical
- 21 School Newark
- 28 *(Sponsored by CMDNJ-New Jersey Medical School*
and Academy of Medicine)
- 10 **Pseudo-Tumors, 1976 Update**
- 8 p.m. — Schering Corporation, Kenilworth
- (Sponsored by Academy of Medicine, and New Jersey*
Dermatological Society)
- 10 **Current Treatment of Burns**
- 10 a.m. — North Hudson Hospital, Weehawken
- (Sponsored by North Hudson Hospital and Academy of*
Medicine)
- 10 **Breast Cancer**
- 8 p.m. — Paul Kimball Hospital, Lakewood
- (Sponsored by Paul Kimball Hospital and Academy of*
Medicine)
- 10 **Fluid and Electrolyte Imbalance**
- 9 p.m. — Bayonne Hospital
- (Sponsored by Bayonne Hospital and Academy of*
Medicine)
- 11 **Differential Diagnosis of Arthritis**
- 1 p.m. — VA Hospital, Lyons
- (Sponsored by VA Hospital and Academy of Medicine)*
- 11 **Monthly Neuro-Radiology Meetings**
- 7:45-10:15 p.m. — Morristown Memorial Hospital
- (Sponsored by Radiological Society of New Jersey and*
Academy of Medicine)
- 11 **Peritoneoscopy**
- 1 p.m. — Christ Hospital, Jersey City
- (Sponsored by Christ Hospital, Jersey City)*
- 11 **Anesthesia Conferences**
- 8-9 p.m. — West Jersey Hospital, Voorhees
- (Sponsored by West Jersey Hospital and University of*
Pennsylvania School of Medicine)
- 11 **Family Practice Multidiscipline Conference**
- 25 12:30 p.m. — Overlook Hospital, Summit
- (Sponsored by Overlook Hospital and AAFP)*
- 12 **Antibiotic Selection**
- 12 noon — Monmouth Medical Center, Long Branch
- (Sponsored by Monmouth Medical Center and AAFP)*
- 12 **Cervical and Uterine Cancer**
- 1 a.m. — Monmouth Medical Center, Long Branch
- (Sponsored by Monmouth Medical Center and AAFP)*
- 12 **Internal Medicine/Family Medicine Visiting**
Professorships
- 26 12 noon-1 p.m. — Monmouth Medical Center, Long
Branch
- (Sponsored by Monmouth Medical Center and AAFP)*
- 13 **Monthly Scientific Meeting**
- 8:30 p.m. — Hackensack Hospital
- (Sponsored by New Jersey Psychoanalytic Society and*
Academy of Medicine)
- 16 **1975-76 Lecture Series**
- 12 noon — Montclair Community Hospital
- (Sponsored by Montclair Community Hospital and*
Academy of Medicine)
- 17 **Pacemakers**
- 11:30 a.m. — St. Mary's Hospital, Orange
- (Sponsored by St. Mary's Hospital)*
- 17 **Joint Neurological-Neurosurgical Conferences**
- 11:30 a.m. — Pascack Valley Hospital, Westwood
- (Sponsored by Pascack Valley Hospital and Academy*
of Medicine)
- 17 **Radiology of Genitourinary Disease**
- 7-9:30 p.m. — VA Hospital, East Orange
- (Sponsored by CMDNJ-New Jersey Medical School,*
VA Hospital, and Academy of Medicine)
- 18 **Advances in Management of Tuberculosis**
- 1 p.m. — Trenton Psychiatric Hospital
- (Sponsored by Trenton Psychiatric Hospital and*
Academy of Medicine)
- 18 **Annual Meeting**
- 7 p.m. — Forsgate Farms Country Club, Jamesburg
- (Sponsored by American Diabetes Association [New*
Jersey Affiliate] and Academy of Medicine)
- 18 **Special Problems in Neurology**
- 7 p.m. — VA Hospital, East Orange
- (Sponsored by CMDNJ-New Jersey Medical School,*
VA Hospital and Academy of Medicine)

- 18 **Protection of Ischemic Myocardium in Man**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 20 **Pediatric Endocrinology**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 20 **Diabetes**
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
 - 21 **Pediatric Surgery**
9 a.m.-12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 24 **Management of the High-Risk Neonate**
7-10 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 24-27 **Emergency Medical Conferences**
9 a.m.-4 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 24 **Proper Use of Endoscopy**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
 - 24 **Peripheral Vascular Disease**
11 a.m. — Perth Amboy General Hospital
(Sponsored by Perth Amboy General Hospital and Academy of Medicine)
 - 24 **Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
 - 25 **Dysfunctional Uterine Bleeding**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)
 - 25 **Acupuncture**
2 p.m. — Cherry Hill Medical Center
(Sponsored by Cherry Hill Medical Center and Academy of Medicine)
 - 26 **Cryptococcus**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 26 **Renal Angiography**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
 - 27 **Cardiac Arrhythmias**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 28 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and VA Hospital)
- Mar.
- **General Surgery Continuing Education**
3 p.m. (every Monday, Thursday, Friday) — Atlantic City Hospital
(Sponsored by Atlantic City Hospital)
 - 1 **Distinguished Lectures in Surgery**
8 4-5 p.m. — Martland Hospital Unit, Newark
15 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
29
 - 1 **Congestive Heart Failure**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)
 - 1 **Medical-Legal Aspects of Medicine and Surgery**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
 - 2 **Psychiatric Case Conferences**
9 7:30-9:30 a.m. — Trenton Psychiatric Hospital
16 (Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
23
30
 - 2 **Topics in Neurosurgery**
9 4-5 p.m. — VA Hospital, East Orange
16 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)
23
30
 - 2 **Medical-Legal Aspects of Medicine and Surgery**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
 - 3 **Perinatal Seminars**
10 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
17 (Sponsored by Newark Beth Israel Medical Center)
24
31
 - 3 **Conferences in Endocrinology**
10 3:30-5 p.m. — Location to be announced
17 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, Newark Beth Israel Medical Center and Academy of Medicine)
24
31
 - 3 **Hormones in Office Gynecologic Practice**
10 **Risk Factors in Breast Cancer**
17 **Breast Problems Encountered in Office Practice**
24 **Epidemiology and Host Susceptibility Factors in Cancer**
31 **Office Dermatology**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
 - 3 **Medical Lecture Series**
10 9-11 a.m. — Riverview Hospital, Red Bank
17 (Sponsored by Riverview Hospital and Academy of Medicine)
24
31
 - 3 **Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange

- (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)*
- 3 **Cardiology Conferences**
 - 17 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)
 - 3 **Liver, Surgery and Biopsy**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital, Academy of Medicine and AAFP)
 - 3 **Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 4 **Advances in Immunology**
 - 11 4-6 p.m. — Institute for Medical Research, Camden
 - 18 *(Sponsored by Institute for Medical Research and AAFP)*
 - 25
 - 5 **Fall-Spring Psychiatric Lecture Series**
 - 12 1:30-5 p.m. — Trenton Psychiatric Hospital
 - 19 *(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)*
 - 26
 - 5 **Fungal Infections**
8:30 a.m. — United Hospitals of Newark
(Sponsored by United Hospitals of Newark and Academy of Medicine)
 - 6 **Nuclear Medical Procedures in Surgery**
10-11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 6 **Advances in Orthopedic Surgery**
 - 13 8:30-11:30 a.m. — CMDNJ, New Jersey Medical School, Newark
 - 20
 - 27 *(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)*
 - 9 **Carcinoma of the Endometrium**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 9 **New Developments in Scanning**
10 a.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of Medicine)
 - 9 **Headache**
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)
 - 9 **Thyroid Diseases**
9 p.m. — West Hudson Hospital, Kearny
(Sponsored by West Hudson Hospital and Academy of Medicine)
 - 9 **Collagen Diseases and Vasculitis — 1976**
Schering Corporation, Kenilworth
(Sponsored by Academy of Medicine and New Jersey Dermatological Society)
 - 10 **Monthly Neuro-Radiology Meetings**
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey and Academy of Medicine)
 - 10 **Anesthesia Conference**
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
 - 10 **Medical-Legal Aspects of Medicine and Surgery**
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by John E. Runnells Hospital and Academy of Medicine)
 - 10 **Cerebral Vascular Disease**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
 - 10 **Management of Advanced Cancer Patient**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 11 **Internal Medicine/Family Medicine Visiting Professorships**
12 noon-1 p.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 11 **Cardiomyopathies**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 12 **Monthly Scientific Meeting**
8:30 p.m. — Hackensack Hospital
(Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine)
 - 12-15 **Revolutionary Trends in Medicine 1976**
Hyatt House, Cherry Hill
(New Jersey AFP Annual Convention)
 - 12 **Headaches in Childhood**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 13 **Diversitary Urologic Surgery**
10-11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 15 **Proper Use of Antibiotics**
11:30 a.m. — Helene Fuld Hospital, Trenton
(Sponsored by Helene Fuld Hospital and Academy of Medicine)
 - 15 **Medical Lecture Series**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 16 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
 - 16 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
 - 16 **Arthritis**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)

- 16 Clinical Immunology**
12 noon — Hospital Center at Orange
(Sponsored by Hospital Center at Orange and Academy of Medicine)
- 17 Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
- 17 Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)
- 17 The Right to Psychiatric Treatment**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 17 Hypertension**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 19 Antenatal and Prenatal Diagnosis of Congenital Defects**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 19 Infertility**
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
- 23 New Developments in Scanning**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
- 23 Tumor Board Visiting Professor Series**
12 noon-1 p.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 24 The Limbic System; Behavior and Epilepsy**
VA Hospital — East Orange
(Sponsored by VA Hospital, East Orange, and Academy of Medicine)
- 25 CA of the Lung**
7:15 p.m.-10:15 p.m. — Hospital Center of Orange
(Sponsored by Academy of Medicine and the Radiological Society of New Jersey)
- 25 Hypertension**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 26 Arthritis**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 27-28 17th Annual Postgraduate Anesthesia Seminar**
Cherry Hill Inn, Cherry Hill
(Sponsored by New Jersey State Society of Anesthesiologists and Academy of Medicine)
- 30 Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- Apr.**
- **General Surgery Continuing Education**
3 p.m. (every Monday, Thursday, Friday) — Atlantic City Hospital
(Sponsored by Atlantic City Hospital)
- 2 Fall-Spring Psychiatric Lecture Series**
9 1:30-5 p.m. — Trenton Psychiatric Hospital
16 (Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
23
30
- 2 Pre-Hospital Coronary Care**
8:30 a.m. — United Hospitals of Newark
(Sponsored by United Hospitals of Newark and Academy of Medicine)
- 3 Advances in Orthopedic Surgery**
10 8:30-11:30 a.m. — CMDNJ-New Jersey Medical School, Newark
17
24 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 5 Distinguished Lectures in Surgery**
12 4-5 p.m. — Martland Hospital Unit, Newark
19 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
26
- 5 Medical-Legal Aspects of Medicine and Surgery**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)
- 5 Current Chemotherapy of Malignant Disease**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
- 6 Topics in Neurosurgery**
13 4-5:00 p.m. — VA Hospital, East Orange
20 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)
27
- 6 Psychiatric Case Conferences**
13 7:30 a.m. — Trenton Psychiatric Hospital
20 (Sponsored by Trenton Psychiatric Hospital)
27
- 6 Comprehensive Review of Chemotherapy in Psychiatry**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
- 7 Perinatal Seminars**
14 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
21 (Sponsored by Newark Beth Israel Medical Center and Academy of Medicine)
28
- 7 Pathogenesis and Management of Uremia**
14
21
28
- Sensory Feedback in Neurological Disorders**
21
- Basic Principles of Behavior Therapy**
21
- Medical Aspects of the Psychiatric Consultation**
9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

- 7 Distinguished Lectures in Obstetrics and Gynecology
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 7 Conferences in Endocrinology
- 14 3:30-5 p.m. — Location to be announced
- 21 (Sponsored by CMDNJ-New Jersey Medical School,
- 28 VA Hospital, East Orange, Newark Beth Israel Medical Center and Academy of Medicine)
- 7 Cardiology Conferences
- 21 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)
- 7-9 Emergency Medicine Conferences (Three Day Sessions)
9 a.m.-4 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 7 Neurology-Headache
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital, Academy of Medicine, and AAFP)
- 7 Conferences in Endocrinology
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 7 Monthly Meeting
8-10 p.m. — Morristown Memorial Hospital
(Sponsored by New Jersey Gastroenterological Society and Academy of Medicine)
- 8 Internal Medicine/Family Medicine Visiting Professorships
- 22 12 noon-1 p.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 8 Shock in Newborn
11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 9 Chronic Osteomyelitis in Childhood
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 9 Monthly Scientific Meeting
8:30 p.m. — Hackensack Hospital
(Sponsored by New Jersey Psychoanalytic Society and Academy of Medicine)
- 10 Pharmacology of New Anesthetic Agents
10-11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 13 Clinical Endocrinology
8 p.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hudson Hospital and Academy of Medicine)
- 13 Clinical Immunology
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine)
- 13 Diabetes
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)
- 13 Clinical Pathological Conference
8 p.m. — Johnson & Johnson, New Brunswick
(Sponsored by Academy of Medicine and New Jersey Dermatological Society)
- 14 Monthly Neuro-Radiology Meetings
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey)
- 14 Anesthesia Conferences
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and University of Pennsylvania School of Medicine)
- 15 Renal Regulation of Sodium Excretion
Somerset Hospital, Somerville
(Sponsored by Nephrology Society of New Jersey, N.J. RMP and Academy of Medicine)
- 16 Surgical Management of Ulcerative Colitis
12 noon — Freehold Area Hospital
(Sponsored by Freehold Area Hospital and Academy of Medicine)
- 17 Monitoring of the High Risk Patient
9 a.m. — St. Barnabas Hospital, Livingston
(Sponsored by St. Barnabas Hospital, Department of Surgery)
- 19 Medical Lecture Series
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- 20 Joint Neurological-Neurosurgical Conferences
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
- 20 Radiology of Genitourinary Disease
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
- 20 Dermatology
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
- 21 Recent Advances in Pulmonary Disease
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
- 21 Special Problems in Neurology
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange and Academy of Medicine)
- 21 Treatment of Pain; Medical & Neurosurgical
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)

- 21 Thyroid Diseases**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital and Academy of Medicine)
- 21 Geriatric Psychiatric Syndromes with Review of Chemotherapy**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and Academy of Medicine)
- 22 The Middle Ear**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
- 22 Therapy of Diabetes**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 27 Clinical Pathological Conferences**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and Academy of Medicine)
- 27 Trauma-Outpatient Department**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)
- 28 Management of the Diabetes Patient**
9 a.m.-5 p.m. — Rutgers Medical School, Piscataway
(Sponsored by American Diabetes Association and AAFP)
- 30 Diagnosis of the Anemic Patient**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- May**
— **General Surgery Continuing Education**
3 p.m. (every Monday, Thursday, Friday) — Atlantic City Hospital
(Sponsored by Atlantic City Hospital)
- 1 Advances in Orthopedic Surgery**
8 8:30-11:30 a.m. — CMDNJ, New Jersey Medical School, Newark
15 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 3 Distinguished Lectures in Surgery**
10 4-5 p.m. — Martland Hospital Unit, Newark
17 (Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 3 Anesthesiology**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by Community Memorial Hospital and Academy of Medicine)
- 4 Topics in Neurosurgery**
11 4-5 p.m. — VA Hospital, East Orange
18 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, and Academy of Medicine)
- 4 New Developments in Scanning**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and Academy of Medicine)
- 4 Psychiatric Case Conferences**
11 7:30 a.m. — Trenton Psychiatric Hospital
19 (Sponsored by Trenton Psychiatric Hospital)
- 5 Renal Tubular Dysfunction**
12 Intestinal Absorption and Malabsorption
19 The Future of Allergy
26 Office Use of Antibiotics
9:00-11:00 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)
- 5 Conferences in Endocrinology**
12 3:30-5 p.m. — Location to be announced
19 (Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, East Orange, Newark Beth Israel Medical Center and Academy of Medicine)
- 5 Perinatal Seminars**
12 9:30 a.m.-2 p.m. — Newark Beth Israel Medical Center
19 (Sponsored by Newark Beth Israel Medical Center)
- 5 Distinguished Lectures in Obstetrics and Gynecology**
6 p.m. — Carriage Trade, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 5 Cardiology Conferences**
19 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(Sponsored by CMDNJ-Rutgers Medical School and Academy of Medicine)
- 5 Conferences in Endocrinology**
6 p.m. — Holiday Inn, East Orange
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
- 5 Peripheral Vascular Disease**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital, Jersey City)
- 6 Internal Medicine/Family Medicine Visiting Professorships**
12 noon-1 p.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
- 7 Fiberoptic Bronchoscopy**
8:30 a.m. — United Hospitals of Newark
(Sponsored by United Hospitals of Newark and Academy of Medicine)
- 11 Arthritis**
10 a.m. — North Hudson Hospital, Weehawken
(Sponsored by North Hospital and Academy of Medicine)
- 11 Emergency Medicine**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by Paul Kimball Hospital and Academy of Medicine)
- 11 Laboratory Interpretations**
9 p.m. — West Hudson Hospital, Kearny
(Sponsored by West Hudson Hospital and Academy of Medicine)
- 11 Arthritis**
9 p.m. — Bayonne Hospital
(Sponsored by Bayonne Hospital and Academy of Medicine)

- 12 **Anesthesia Conferences**
8-9 p.m. — West Jersey Hospital, Voorhees
(Sponsored by West Jersey Hospital and School of Medicine)
 - 12 **Office Treatment of Depression**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 12 **Monthly Neuro-Radiology Meetings**
7:45-10:15 p.m. — Morristown Memorial Hospital
(Sponsored by Radiological Society of New Jersey)
 - 12 **Recent Advances in Pulmonary Disease**
11:30 a.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
 - 12 **Chronic Renal Failure**
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by John E. Runnells Hospital and Academy of Medicine)
 - 13 **Management of Hyperlipidemias**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 13 **Genetics**
11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 15 **Inflammatory Bowel Disease**
10-11 a.m. — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 17 **Medical Lecture Series**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
 - 18 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(Sponsored by Pascack Valley Hospital and Academy of Medicine)
 - 18 **Radiology of Genitourinary Disease**
7-9:30 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
 - 18 **Headache**
11:30 a.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
 - 18 **Drug Addiction**
12 noon — Hospital Center at Orange
(Sponsored by Hospital Center at Orange and Academy of Medicine)
 - 19 **Special Problems in Neurology**
7 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ-New Jersey Medical School, VA Hospital, and Academy of Medicine)
 - 19 **Diabetes Mellitus**
1 p.m. — Trenton Psychiatric Hospital
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 - 19 **New Developments in Scanning**
Fair Oaks Hospital, Summit
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 - 19-21 **Emergency Medicine Conferences**
9 a.m.-4 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ-New Jersey Medical School and Academy of Medicine)
 - 20 **To be announced**
7:15-10:15 p.m. — Hospital Center at Orange
(Sponsored by Academy of Medicine and Radiological Society of New Jersey)
 - 21 **Management of Hepatitis**
12 noon — Freehold Area Hospital
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 - 21 **Management of End State Renal Disease**
2 p.m. — Cherry Hill Medical Center
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 - 21 **Abnormalities in Growth Patterns in Childhood and Adolescence**
12 noon — Monmouth Medical Center, Long Branch
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 - 25 **Clinical Pathological Conferences**
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 - 25 **Drug Addiction**
8 p.m. — Warren Hospital, Phillipsburg
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 - 26 **Annual Awards Dinner**
6:30 p.m. — The Chanticleer, Millburn
(Sponsored by Academy of Medicine)
 - 26 **Child Abuse Revisited**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 27 **In Vitro Studies of Erythropoiesis**
12 noon — Monmouth Medical Center, Long Branch
(Sponsored by Monmouth Medical Center and AAFP)
 - 28 **Thyroid Diseases**
12 noon — Montclair Community Hospital
(Sponsored by Montclair Community Hospital and Academy of Medicine)
- June
- **General Surgery Continuing Education**
3 p.m. (every Monday, Thursday, Friday) — Atlantic City Hospital
(Sponsored by Atlantic City Hospital)
- 1 **Topics in Neurosurgery**
 - 8 4-5 p.m. — VA Hospital, East Orange
 - 15 (Sponsored by CMDNJ-New Jersey Medical School,
 - 22 VA Hospital, and Academy of Medicine)
 - 29

- 1 **Psychiatric Case Conferences**
8 7:30-9:30 a.m. — Trenton Psychiatric Hospital
15 (*Sponsored by Trenton Psychiatric Hospital and*
22 *Academy of Medicine*)
29
- 2 **Obstructive Lung Disease**
1:00 p.m. — Christ Hospital, Jersey City
(*Sponsored by Christ Hospital and Academy of*
Medicine)
- 2 **Cardiology Conferences**
16 4-5:30 p.m. — CMDNJ, Rutgers Medical School
(*Sponsored by CMDNJ-Rutgers Medical School and*
Academy of Medicine)
- 4-8 **MSNJ Annual Meeting**
Cherry Hill Hyatt House
Cherry Hill
- 4 **Fluid and Electrolyte Imbalance**
8:30 a.m. — United Hospitals of Newark
(*Sponsored by CMDNJ-Rutgers Medical School and*
Academy of Medicine)
- 5 **Advances in Orthopedic Surgery**
12 8:30-11:30 a.m. — CMDNJ, New Jersey Medical
19 School, Newark
26 (*Sponsored by CMDNJ-New Jersey Medical School*
and Academy of Medicine)
- 7 **Thyroid Diseases**
8 p.m. — Community Memorial Hospital, Toms River
(*Sponsored by Community Memorial Hospital and*
Academy of Medicine)
- 8 **Tuberculosis**
11 a.m. — Greystone Park Psychiatric Hospital
(*Sponsored by Greystone Park Psychiatric Hospital*
and Academy of Medicine)
- 8 **Trauma and the Emergency Department**
9 p.m. — Bayonne Hospital
(*Sponsored by Bayonne Hospital and Academy of*
Medicine)
- 8 **Acute Renal Failure**
8 p.m. — Paul Kimball Hospital, Lakewood
(*Sponsored by Nephrology Society of New Jersey, N. J.*
RMP, and Academy of Medicine)
- 9 **Thanatology**
1:30 p.m. — John E. Runnells Hospital, Berkeley
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(*Sponsored by John E. Runnells Hospital and Academy*
of Medicine)
- 9 **Anesthesia Conferences**
8-9 p.m. — West Jersey Hospital, Voorhees
(*Sponsored by West Jersey Hospital and University of*
Pennsylvania School of Medicine)
- 12 **Antibiotics and Surgical Infection**
10-11 a.m. — Monmouth Medical Center, Long Branch
(*Sponsored by Monmouth Medical Center and AAFP*)
- 15 **Joint Neurological-Neurosurgical Conferences**
11:30 a.m. — Pascack Valley Hospital, Westwood
(*Sponsored by Pascack Valley Hospital and Academy*
of Medicine)

OBITUARIES

Dr. Charlotte H. Cahrssen

Charlotte H. Cahrssen, M.D., an Essex County psychiatrist, died on October 14, 1975. A native of Germany, Dr. Cahrssen received her premedical education in Berlin and Vienna and earned her medical degree from the University of Marburg in Germany in 1948. She emigrated to the United States in 1952 and worked briefly in Chicago and at Presbyterian Hospital in Newark before accepting appointment as staff psychiatrist at the Essex County Overbrook Hospital in Cedar Grove (now renamed the Essex County Hospital Center), where she remained until 1963 when she established a private practice in Orange. Dr. Cahrssen was a member of the American Medical Women's Association and had been actively associated with the Essex County Mental Health Clinics.

Dr. Ethan T. Colton, Jr.

Ethan T. Colton, Jr., M.D., who formerly practiced obstetrics and gynecology in Montclair, died on October 1, 1975, at Montclair Community Hospital. A native of New York City, Dr. Colton was graduated from Harvard Medical School in 1929 and following graduate work in obstetrics and gynecology he came to New Jersey in 1935 to practice that specialty. He had been on the staff at the Community and Mountainside Hospitals in Montclair and at Bellevue Hospital in New York until retirement in 1970. He was a member of the International Fertility Association, the American Society of Abdominal Surgeons, and the Anatomical Pathologic Society. Dr. Colton was elected to emeritus membership in 1971. He was 71 years old at the time of his death.

Dr. Armin Docter

Word has just been received of the death on March 2, 1974, of Armin Docter, M.D., formerly of Englewood. Born in 1913 and a graduate of the University of Berne (Switzerland) in 1938, Dr. Docter practiced general medicine in Bergen County until retirement, because of illness, to New York City in 1967. However, he retained membership in the Bergen County Medical Society. Dr. Docter was a Fellow of the American Academy of Family Physicians.

Dr. Joseph Goldmann

A former East Orange practitioner, Joseph Goldmann, M.D., died in Trenton on October 12, 1975, after a prolonged illness. Born in 1907, Dr. Goldmann received his medical degree from the Medical School of the University of Berlin in 1937. Following internship he returned to New Jersey and practiced here for 33 years until a physical disability forced his retirement in 1971. He had been on the staff at the East Orange General Hospital as a general practitioner with special interest in diabetes. Dr. Goldmann's present home was at Rossmoor, Jamesburg.

Dr. Marcus H. Greifinger

One of Essex County's renown members, Marcus H. Greifinger, M.D., died on October 21, 1975 after a prolonged illness. (See editorial comment, page 1003, this issue.) Born at the turn of the century and a graduate of the University of Maryland, class of 1924, he pursued graduate work in surgery and earned Fellowship in the American College of Surgeons. He had been on the active staff at Newark City, St. James, and Clara Maass Hospitals, and was a member of the prestigious New Jersey Society of Surgeons. Dr. Greifinger was Secretary of his county society for 16 years and served one term as its president, 1956-1957. On the State level, he was Secretary of MSNJ from 1949 through 1969 (when illness forced his resignation) and had been an AMA Delegate from 1961 to 1970. He was a recipient of MSNJ's Golden Merit Award in 1974. In his home community of Newark, Dr. Greifinger had served as police surgeon for nearly 25 years.

Dr. Martin Siegelman

At the untimely age of 41, the promising career of Martin Siegelman, M.D., came to an end with his death on October 6, 1975, after a long illness. A graduate of Cornell Medical School, class of 1959, Dr. Siegelman served two and a half years in the medical department of the U.S. Army and completed a three-year residency in obstetrics and gynecology at Saint Luke's Medical Center in New York, before establishing a practice in Middlesex County. He was board certified in his chosen specialty and was a Fellow of the American College of Obstetrics and Gynecology. Dr. Siegelman was on the attending staffs at both Middlesex General and Saint Peter's Hospitals in New Brunswick.

Dr. Valfrids Viksne

One of Ocean County's senior physicians Valfrids Viksne, M.D., of Lakewood, died in Paul Kimball Hospital on October 4, 1975. Born in Latvia in 1902 and a recipient of a medical degree from that university in 1933, Dr. Viksne came to New Jersey in 1957 and practiced general medicine briefly while pursuing graduate work in psychiatry, before accepting a staff appointment at the Marlboro Psychiatric Hospital, where he remained until retirement in 1972. Dr. Viksne was a member of the New Jersey and American Psychiatric Associations.

Dr. Edward E. Wolfe

We have just learned of the death on July 23, 1975, of Edward E. Wolfe, M.D., an emeritus member of our Bergen County component. A graduate of the Medical College of the University of Louisville, class of 1931, Dr. Wolfe practiced internal medicine in Teaneck for many years before retiring to Florida in 1972. He had been on the staff in the medical department at Holy Name Hospital and chief of the diabetes service there, and was also affiliated with the Bergen Pines Hospital in Paramus. He was a member of the American Diabetes Association and a Fellow of the Academy of Medicine of New Jersey. During World War II, Dr. Wolfe served for four years in the medical department of the Army.

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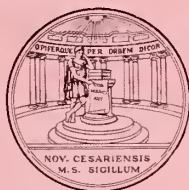
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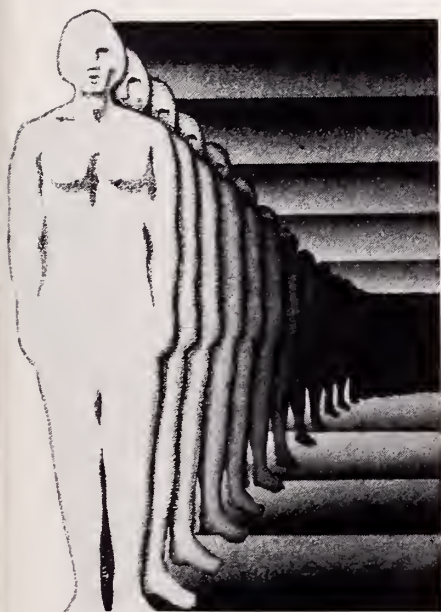
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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous

occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety and tension, 5 to 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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CYSTITIS***

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due to susceptible
organisms



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RELIEVE THE PAIN WHILE YOU ELIMINATE THE PATHOGENS.

FOR THE PAIN

- ☐ Early relief of painful symptoms such as burning and pain associated with urgency and frequency.

FOR THE PATHOGENS

- ☐ Effective control of susceptible pathogens such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. au-*

reus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

Appropriate antibacterial therapy: Up to 3 days therapy with Azo Gantrisin 4 to 6 tablets *Stat.*, then 2 tablets *q.i.d.*; then 11 days with Gantrisin (sulfisoxazole) may be considered.

AZO GANTRISIN®

(50 mg phenazopyridine HCl and 0.5 Gm sulfisoxazole)

2382-41-8 ZC

Before prescribing, please consult complete product information, a summary of which follows.

Indications: In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Important Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, periph-

eral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

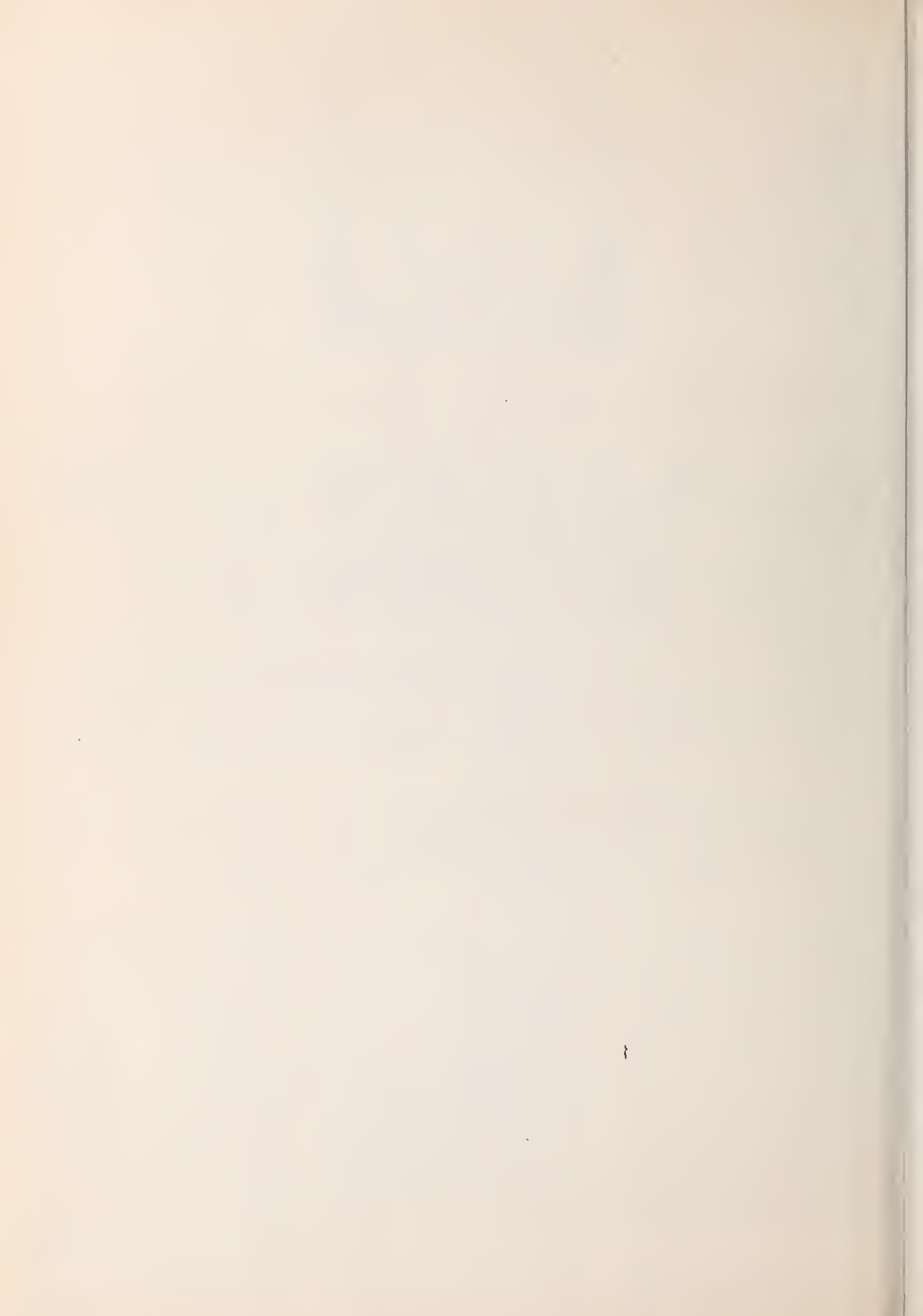
Dosage: Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole) may be considered.

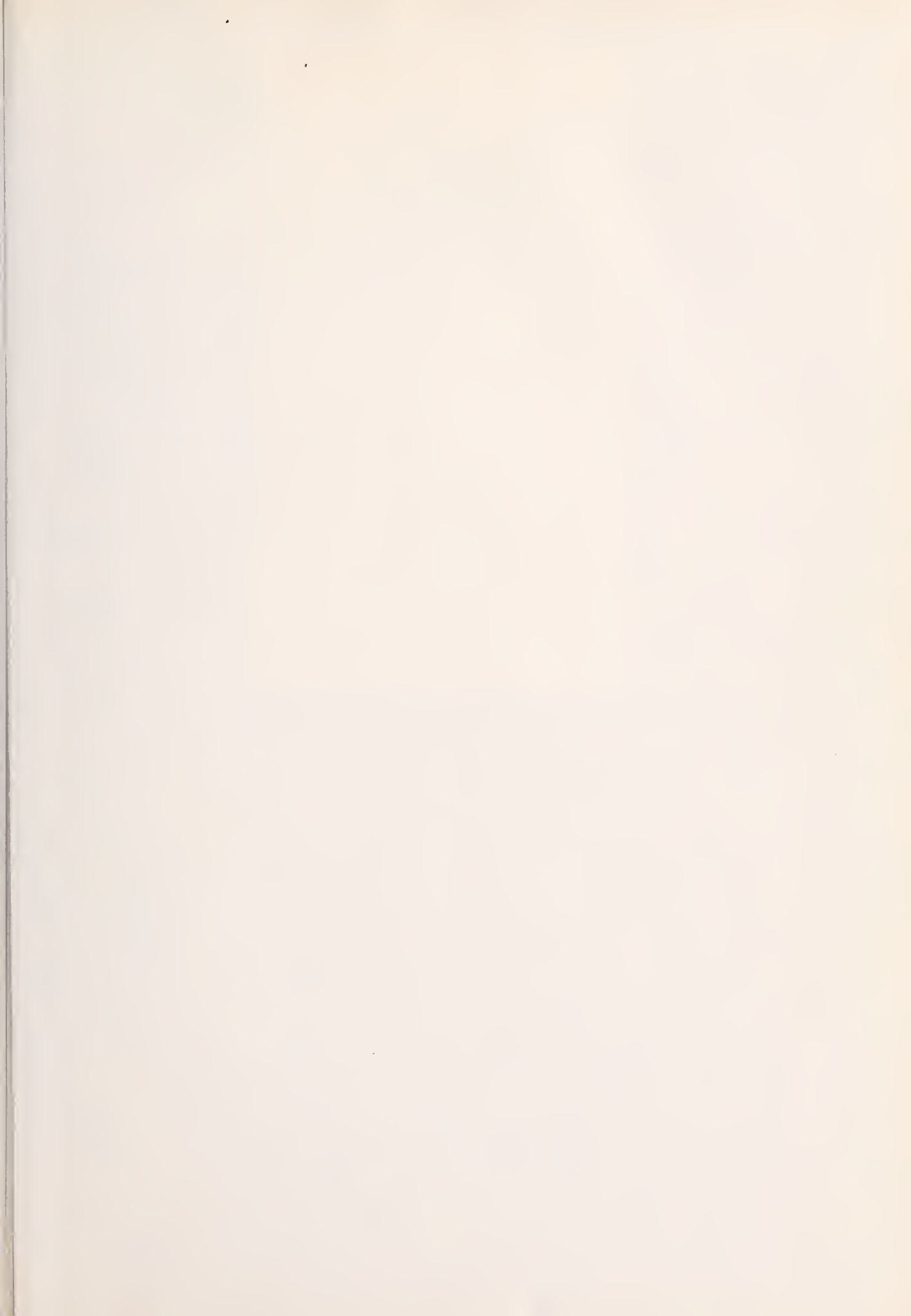
Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl—bottles of 100 and 500.

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DUE IN TWO WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 6 WEEKS

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